STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235427	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN WOODS RESIDENTIAL HLTH	29800 HOOVER RD WARREN, MI 48093

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to intake numbers: 4, 6, and 4. Based on interview and record review, the facility failed to ensure contact of a responsible party and/or family member for three sampled residents (R500, R505, and R508) who experienced a change in their medical condition of seven residents reviewed for change of condition, resulting in the potential for a delay in treatment and/or psychosocial harm. Findings include: R508 On [DATE] at 9:19 AM, a review of R508's vitals in their Electronic Health Record (EHR) revealed the following, on [DATE] at 11:00 AM R508 had a temperature of 100.9 degrees Fahrenheit; On [DATE] at 4:00 PM, R508 had a temperature of 100.9 degrees Fahrenheit. Review of R508's EHR revealed a progress note dated, [DATE] 10:45 AM which stated, Resident has a temperature of 100.9 SPO2 90% (Blood Oxygen Saturation Level) (Normal level is 95%) .Resident is lethargic. A progress note dated [DATE] at 11:38 PM stated, .Resident had mouth full of white thick sputum, (Mixture of Saliva and Mucus) unable to spit out, suctioned and removed a lot of white thick sputum . R508's EHR indicated that R508 died at the facility on [DATE] and that R508's Responsible Party (RP) was contacted. On [DATE] at 9:53 AM, Confidential Family Member (CFM) C was contacted by phone regarding R508 and stated, They never notified me about R508's medical changes on [DATE], we could have taken her to the hospital or said our goodbyes, I feel bad for my mother. They usually called me about everything. On [DATE] at 10:15 AM, Nurse J was contacted by phone and queried about if they had contacted R508's Responsible Party (RP) and/or a family member when R508 began having a change in their medical condition on [DATE]. Nurse J stated It should be in a progress note or in the SBar communication. On [DATE] at 10:17 AM, a review of R508's progress notes and SBar communication did not reveal any documentation involving notification of R508's RP or any other family member involving R508's medical changes on [DATE]. On [DATE] at 10:27 AM, Nurse I was contacted by phone and queried about if they had contacted R508's RP and/or a family member when R508 began having a change in their medical condition on [DATE]. Nurse I stated, I don't remember anything about that resident. On [DATE] at 3:15 PM, the Director of Nursing (DON) was queried about the change in condition of R508 and if staff should have contacted R508's RP and/or a family member when the changes began on [DATE]. The DON stated, They should have called them. On [DATE] at 8:15 AM, a review of R508's EHR indicated an admission to the facility on [DATE] with [DIAGNOSES REDACTED]. R508's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a severely impaired cognition and that R508 required extensive one person assistance with all activities of daily living (ADLs). On [DATE] at 2:30 PM, a facility policy titled, Changes In Resident Condition Revised ,[DATE] revealed the following, The resident .personal representative are notified when changed in condition or certain events occur . Guidelines 2. .The resident's personal representative will be contacted and informed of status. R500 On [DATE] at 3:02 PM, Confidential Witness Z was interviewed regarding R500's care in the facility. Witness Z explained that on [DATE], the resident had leg pain and an X-Ray of their femur was ordered. Witness Z stated that facility did not inform them at the time of the ordered X-Ray, and stated they thought the X-Ray had been negative but was not sure. Witness Z then stated that R500 was sent out to the hospital around [DATE]nd for an unrelated matter and was found to have a fractured femur and had surgery to repair it. Witness Z explained that the facility told them they were investigating the matter but never got back to them about it. A review of R500's medical record revealed the following progress note: [DATE] 14:57 (2:57 PM) Health Status Note Note Text: Resident was seen by (doctor) and new order X-ray of left femur. Notify (doctor) with results. Will continue to monitor. Written by Licensed Practical Nurse (LPN) L. No documentation was found indicating the resident's Guardian/Responsible Party/Emergency Contact was contacted regarding the X-Ray order. No corresponding assessments for the [DATE] progress note were noted to be present in the resident's medical record. On [DATE] at 9:08 AM, LPN L was interviewed via phone and queried regarding R500's X-Ray order on [DATE] and corresponding progress note. LPN L stated, What happened was (R500's) leg looked to be broken. I called (the doctor) and got an order to get an X-Ray of the leg. They ended up sending (R500) out on a different shift for something else. I don't know what happened with the results but I did order it. When queried if it is facility protocol to call the resident's responsible party (RP) when an X-Ray gets ordered, LPN L stated, Yes. I can't remember if I called (R500's RP) or not. And usually we call them after we get the results and let them know. I can't remember if I did or not. When queried if the facility investigated why the resident's leg looked broken, LPN L stated, Not to my knowledge. We didn't find out that it was actually broken until (R500) was transferred out and came back. When asked about the results of the ordered X-Ray, LPN L stated, Not sure, never saw any results. A review of R500's medical record revealed that the resident was admitted into the facility on [DATE] and most recently re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was moderately cognitively impaired and required total assistance from staff for bed mobility, transfers, dressing, toileting and hygiene. R505 A review of intake MI 056 revealed a complaint that the responsible party for R505 was not contacted after a change in condition and medical decline in the two weeks preceding their death in the facility. The intake alleged, (I was informed) that (R505) had been declining for two weeks and it wouldn't of mattered if they told me earlier because I wouldn't of been able to see (R505) because of the (visitation restrictions due to COVID-19) .I never received one phone call from the facility before the call of (R505's) death .They took (our) chance to say goodbye away. One phone call could of changed that all, we could of had closure. A review of R505's medical record revealed the resident was admitted into the facility on [DATE] and most recently re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was severely cognitively impaired and required extensive to total assistance from staff for bed mobility, transfers, dressing, eating, hygiene, and bathing. A review of R505's progress notes and record revealed the following: [DATE] 13:41 (1:41 PM) Health Status Note Text: Resident appetite decreased, fatigue, wheezing, productive cough, CXR (chest X-Ray) ordered (end of note). Created by Licensed Practical Nurse (LPN) M. SBAR (Situation, Background, Assessment, Recommendation) Communication Form and progress note, Date: [DATE] 15:34 (3:34 PM) .The change in condition, symptoms, or signs I am calling about is/are: Resident has decreased appetite, coughing/wheezing, and dyspnea. This started on: [DATE] .Name of Family/Health Care Agent Notified: notified by previous nurse. Date and Time: (blank). No corresponding documentation was noted in the record to verify that the previous nurse (unknown name) notified family/POA/RP of this change in condition. [DATE] 16:00 (4:00 PM) Health Status Note Text: Resident had decreased appetite today, ate less than 25% for breakfast and lunch, resident was given a breathing tx (treatment). administered as ordered. Writer also called and notified (doctor) about CXR results showing no active disease, physician notified of residents decline in appetite, no new orders at this time. [DATE] 15:26 (3:26 PM) Health Status Note Text: Received resident lying in bed with increase congestion. Spo2 (oxygen saturation) was 88% (normal is generally ,[DATE]%). Nebulizer tx given and 02 (supplemental oxygen) increased to 3l (3 liters per minute). Spo2 is 95%. Resident consumed only 50% of breakfast and lunch. [DATE] 14:55

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) (2:55 PM) Health Status Note Text: Received resident resting in bed. Resident is on 5l (5 liters per minute) of O2 via NC (nasal cannula), Spo2 is 88%, R (respiratory rate)-24 (normal respiratory rate is ,[DATE] breaths per minute). Nebulizer tx administered. Resident refused medications and all meals. Report given to oncoming nurse. Doctor is aware of decline. R505's remaining progress notes and assessments from [DATE] through [DATE] were reviewed. No documentation was noted in R505's record that indicated the resident's Power of Attorney (POA)/Responsible Party (RP) was notified of the change in condition. Further review revealed the resident's code status was Do Not Resuscitate (DNR) and the resident was not receiving hospice services. On [DATE] at 10:13 AM, the NHA and Director of Nursing (DON) were interviewed. When queried if a resident's responsible party is to be notified of an X-Ray that is ordered, the DON stated, Any time there's a change in condition we try to notify family. On [DATE] at 1:03 PM, an attempt was made to contact former employee LPN M, however the phone number provided indicated the person was not available. On [DATE] at 2:58 PM, a request was made to the NHA via email to provide any proof of communication with the POA/RP of R505 in 2020. On [DATE] at 8:38 AM, the NHA stated, Other than what is in the record, we have no communications from (R505 family/RP). On [DATE] at 8:43 AM, the DON was queried regarding the requested documentation of POA/RP notification of R505's decline. The DON stated, It would be in the progress notes. The DON was then asked to read the progress note for R505 dated [DATE] at 1:41 PM, and asked if the resident's POA/RP should have been notified. The DON indicated the resident appeared to be declining and stated, Yes. Should have been notified. They could have had an opportunity to come visit. A review of the facility's policy titled, Changes in Resident Condition, revised ,[DATE], revealed: Information: An acute change of condition (ACOC) is a sudden, clinically important change from a resident's established/documented baseline in physical, cognitive, behavioral, or functional status . a primary goal of identifying ACOC's is to facilitate staff evaluation and management of the residents at the facility, and avoiding a transfer to the hospital or emergency room . The facility staff must recognize an ACOC and identify its nature, cause, and severity to effectively assess, treat, and monitor the ACOC. The resident, attending physician, and personal representative are notified when changed in condition or certain events occur. Communication with the interdisciplinary team and caregivers is also important to ensure that consistency and continuity are maintained for the residents benefit .2. For non-life threatening events - the License nurse will begin an SBAR assessment located in PCC. The Licensed nurse will complete the full assessment .This assessment includes a head-to-toe physical assessment .The physician will be contacted with assessment findings and licensed nurse is to proceed with orders .Staff will document resident status at least every 2 hours showing evidence of monitoring. The resident's personal representative will be contacted and informed of status .Depending upon outcome of the SBAR findings, if the resident remains at the facility for further evaluation, the resident will be placed on the 24 hour report. The unit manager or supervisor will be made aware of the resident's status. Each preceding shift will complete another SBAR assessment making comparisons to the previous. The attending physician will be contacted if changes occur from one assessment to the next. This will continue every shift until the ACOC resolves or resident is transferred from the facility. The resident will remain on the 24 hour report for the duration. There will be evidence of a complete assessment and follow up by each preceding nurse.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 6 Based upon interview and record review, the facility failed to ensure that an accurate skin assessment was completed on admission for one sampled resident (R506) of two residents reviewed for assessment, resulting in the potential for inaccurate care plans and unmet care needs. On 7/14/20 at 9:00 AM, a review of R506's skin assessment completed at the time of their admission to the facility on [DATE], by Nurse Manager K indicated the following, Site: Left Elbow, Type: DTI (Deep Tissue Injury) Length: 3cm (centimeters) Width: 3cm, Details/Comments: Peg Tube abdomen, scattered bruising. On 7/14/20 at 3:14 PM, a review of R506's Electronic Health Record (EHR) revealed a progress note dated 4/28/20 which indicated that NM K spoke with R508's son and daughter in law regarding scabs observed on R's face by family members when they had skyped with the resident. NM K discussed with family that R508 had a history of [REDACTED]. On 7/15/20 at 10:30 AM, NM K was queried regarding the skin assessment they completed at admission on R506. NM K indicated, The resident had bruising all over their body and on their face. I was told that he had multiple falls at his last placement. NM K was queried on if she indicated on the resident's skin assessment the specific location of any bruises and/or marks on the resident. NM K stated, No, I just indicated DTI on elbow and scattered bruising. I learned that I will be more detailed in the future. On 7/15/20 at 3:10 PM, the Director of Nursing was queried on the admission skin assessment completed on R506 by NM K and what their expectations were for completion of a resident's skin assessment. The DON indicated that R506's skin assessment should have included more details about the location of the resident's bruising and any any other marks on their skin. The DON indicated that NM K did not do a very through job on R506's skin assessment. On 7/16/20 at 8:45 AM, a review of R506's EHR revealed an admission to the facility on [DATE] with [DIAGNOSES REDACTED]. R506's most recent Minimum Data Set Assessment ((MDS) dated [DATE] indicated that R506 had a severely impaired cognition. On 7/16/20 at 9:00 AM, a facility policy titled Resident Care Nursing Assessment at time of Admission Revised 1/14/2020 was reviewed and revealed the following, Purpose: To perform a comprehensive resident review at the time of admission in order to ensure the complete and correct assessment of the resident status. Enable the nurses to initiate a baseline care plan and current health care needs as required by State and Federal regulations .
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 4. Based on interview and record review, the facility failed to obtain an X-Ray per physician order for [REDACTED]. Witness Z explained that on 1/9/20, the resident had leg pain and an X-Ray of their femur was ordered. Witness Z stated that facility did not inform them at the time of the ordered X-Ray, and stated they thought the X-Ray had been negative but was not sure. Witness Z then stated that R500 was sent out to the hospital around January 22nd for an unrelated matter and was found to have a fractured femur and had surgery to repair it. Witness Z explained that the facility told them they were investigating the matter but never got back to them about it. A review of R500's medical record revealed the following progress note: 1/9/2020 14:57 (2:57 PM) Health Status Note Note Text: Resident was seen by (doctor) and new order X-ray of left femur. Notify (doctor) with results. Will continue to monitor. Written by Licensed Practical Nurse (LPN) L. No documentation was found indicating the resident's Guardian/Responsible Party/Emergency Contact was contacted regarding the X-Ray order. No corresponding assessments for the 1/9/20 progress note were noted to be present in the resident's medical record. Further review revealed the following order: Xray of left femur. Notify (doctor) with results. No directions specified for order. Diagnostic. ordered on [DATE], discontinued on 1/14/20. On 7/14/20 at 12:52 PM, the Nursing Home Administrator (NHA) was asked to provide any incident/accident (I/A) reports for R500 from January 2020. No I/A's from that time were received prior to survey exit. On 7/15/20 at 9:08 AM, LPN L was interviewed via phone and queried regarding R500's X-Ray order on 1/9/20 and corresponding progress note. LPN L stated, What happened was (R500's) leg looked to be broken. I called (the doctor) and got an order to get an X-Ray of the leg. They ended up sending (R500) out on a different shift for something else. I don't know what happened with the results but I did order it. When queried if it is facility protocol to call the resident's responsible party (RP) when an X-Ray gets ordered, LPN L stated, Yes. I can't remember if I called (R500's RP) or not. And usually we call them after we get the results and let them know. I can't remember if I did or not. When queried if the facility investigated why the resident's leg looked broken, LPN L stated, Not to my knowledge. We didn't find out that it was actually broken until (R500) was transferred out and came back. When asked about the results of the ordered X-Ray, LPN L stated, Not sure, never saw any results. R500's medical record did not include any results or notes from the X-Ray ordered on [DATE]. Further review revealed the resident was transferred to the hospital at 1:00 AM on 1/22/20 for .Blood transfusion hemoglobin 6.2. (R500 family) notified via phone, and would be informed when (R500 is) being transferred . The resident's leg or X-Ray order was not addressed again in the progress notes after 1/9/20 and before the hospital transfer on 1/22/20. A review of R500's Medication Administration Record [REDACTED]. The medication was noted as given on the following dates with corresponding pain scores on a 0 to 10 scale, with 0 being no pain and 10 being severe pain: 1/1 through 1/3 - no administrations 1/4/20 - administered for pain 5/10 1/5/20 - administered for pain 0/10 1/7/20 - administered for pain 9/10 1/8/20 - administered for pain 6/10 1/9/20 - given once for pain 4/10 and again for pain 6/10 1/11/20 - administered for pain 8/10 1/12/20 - administered for pain 0/10 1/15/20 - administered for pain 6/10 1/17/20 - administered for pain 2/10 1/18/20 - given once for pain 7/10 and again for pain 6/10

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) 1/19/20 - given once for pain 8/10 and again for pain 7/10 1/20/20 - given once for pain 8/10 and again for pain 7/10 1/21/20 - administered for pain 8/10. On 7/15/20 at 9:30 AM, The NHA was asked for the diagnostic test results for R500's X-Ray that was ordered on [DATE]. The NHA stated, According to the Unit Coordinator - the X-Ray did not get done so we had no report. When asked if the documentation of why it was not done be in the resident's medical record, the NHA provided no response. The next entered progress note after 1/22/20 in R500's medical record was dated 2/10/20 and read, 2/10/2020 18:43 (6:43 PM) Admission Summary .admitted from the hospital .With the [DIAGNOSES REDACTED]. A review of R500's re-admission hospital documents revealed the following: Operative Report, Documentation Date: January 31, 2020, Preoperative Diagnoses: [REDACTED].Procedures: .Open reduction internal fixation of left femoral shaft fracture with retrograde intramedullary (IM) rod. Initial Evaluation PT (Physical Therapy) Entered On: 2/1/2020 .General Info: .Pt (patient) initially presented to the ED (emergency department) on 1/22 .was sent in from (nursing home) for abnormal labs. Pt was found to have low hemoglobin .Pt was also c/o (complaining of) LLE (left lower extremity) pain and was found to have L (left) femur fracture, subsequently Ortho (orthopedic) service has been consulted and being diagnosed as Left Femoral Shaft Fracture and underwent ORIF (IM rodding) on 1/31/20. On 7/15/20 at 10:13 AM, the NHA and Director of Nursing (DON) were interviewed. When queried as to why the ordered X-Ray on 1/9/20 was not completed, the NHA stated, I found out that the Unit Secretary hadn't put the order through so it did not get done. Then the resident went out to the hospital with a low hemoglobin. The resident had pain that one day but then it wasn't significant after that. The DON added, They started giving (R500) [MEDICATION NAME] on 1/18. When asked to review the MAR for January 2020, the DON acknowledged that [MEDICATION NAME] was given to the resident prior to 1/18 with corresponding pain scores. The DON provided no further information. When queried if a resident's responsible party is to be notified of an X-Ray that is ordered, the DON stated, Any time there's a change in condition we try to notify family. At 10:24 AM, Unit Manager K joined the interview and confirmed that the X-Ray order for R500 on 1/9/20 was not carried out. A review of R500's medical record revealed that the resident was admitted into the facility on [DATE] and most recently re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was moderately cognitively impaired and required total assistance from staff for bed mobility, transfers, dressing, toileting and hygiene. A review of the facility's policy titled, Changes in Resident Condition, revised 5/2020, revealed: Information: An acute change of condition (ACOC) is a sudden, clinically important change from a resident's established/documented baseline in physical, cognitive, behavioral, or functional status . a primary goal of identifying ACOC's is to facilitate staff evaluation and management of the residents at the facility, and avoiding a transfer to the hospital or emergency room . The facility staff must recognize an ACOC and identify its nature, cause, and severity to effectively assess, treat, and monitor the ACOC. The resident, attending physician, and personal representative are notified when changed in condition or certain events occur. Communication with the interdisciplinary team and caregivers is also important to ensure that consistency and continuity are maintained for the residents benefit .2. For non-life threatening events - the License nurse will begin an SBAR assessment located in PCC. The Licensed nurse will complete the full assessment .This assessment includes a head-to-toe physical assessment .The physician will be contacted with assessment findings and licensed nurse is to proceed with orders .Staff will document resident status at least every 2 hours showing evidence of monitoring. The resident's personal representative will be contacted and informed of status .Depending upon outcome of the SBAR findings, if the resident remains at the facility for further evaluation, the resident will be placed on the 24hour report. The unit manager or supervisor will be made aware of the resident's status. Each preceding shift will complete another SBAR assessment making comparisons to the previous. The attending physician will be contacted if changes occur from one assessment to the next. This will continue every shift until the ACOC resolves or resident is transferred from the facility. The resident will remain on the 24 hour report for the duration. There will be evidence of a complete assessment and follow up by each preceding nurse. A review of the facility policy titled, Diagnostic Services, revised 9/2019, revealed: STANDARD: Clinical laboratory and radiology services are provided. POLICY: The following diagnostic services are available twenty-four hours a day, seven days a week: .Radiology . A review of the facility policy titled, Physician Order Policy and Procedure, revised 3/6/2020, revealed: e. Laboratory and other diagnostic tests: Schedule per policy. 10. The licensed nurse notifies the family of the new order and initials the square on the physician order for [REDACTED]. Quality Assurance Measure: Each day the Unit Managers will bring copies of all new orders to morning report and review them with the team. The Unit Manager will then complete a double check to assure that the order was properly transcribed.
F 0693 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1. Based on observation, interview, and record review, the facility failed to complete and document PEG tube (feeding tube) site care per order for two sampled residents (R500, R509) of fifteen reviewed, resulting in and the potential for infection and hospitalization . Findings include: On 7/10/20 at 3:02 PM, Confidential Witness Z was interviewed regarding R500's care in the facility. Witness Z stated that recently, R500 was hospitalized due to a PEG tube (feeding tube directly into stomach from abdomen) site infection and was now under hospice care at the facility. On 7/14/20 at 1:40 PM, Unit Manager (UM) K was asked if R500's PEG tube site could be observed. UM K indicated the resident was no longer utilizing the PEG tube for feedings and had been terminally weaned off of it. UM K also indicated that the site had been infected. Upon lifting up the resident's gown, the dressing on the PEG tube insertion site was saturated with brown/yellow colored drainage and had the date 7/11/20 written on it. The drainage had saturated the drain sponge as well as the ABD pad (absorbent gauze pad) that laid on top. UM K was asked if the dressing was supposed to be changed every day and responded, Yes. The resident's skin had a small open area (approximately the size of the head of a pencil eraser) with reddened base just below the insertion site, and a smaller open area with reddened base to the right of the site in the fold of the stomach. The resident attempted to itch at the area multiple times after the dressing had been removed. A review of the resident's Treatment Administration Records (TARs) for the months of April, May, June, and July 2020. The following was revealed for the order Change PEG site dressing every shift and as needed and monitor for signs/symptoms of infection every shift: No documentation present as completed on day shift on 4/3, 4/4, 4/7, 5/25, 5/30, 6/8, 6/16, and 6/27. The dressing was marked as changed on day shift on 7/11, 7/12, and 7/13, however, the observation of the dressing on 7/14/20 revealed a dressing dated 7/11/20 that was saturated with drainage. No documentation present as completed on night shift on 4/1, 4/3, 4/5 through 4/7, 4/11, 4/15, 4/20, 4/21, 4/25, 4/29, 4/30, 5/1, 5/5, 5/7, 5/9, 5/12, 5/14, 5/17, 5/18, 5/21 through 5/26, 5/29 through 5/31, 6/2 through 6/11, 6/14 through 6/20, 6/22 through 6/24, 7/6 through 7/8, and 7/10 through 7/13. A review of R500's progress notes revealed the following: 3/1/2020 18:46 Health Status Note: Resident .Peg patent and has no drainage at the site . 5/10/2020 11:14 Health Status Note: Resident .peg site clean and dry. 6/19/2020 22:37 Health Status Note: Redness and warmth noted to abd (abdomen). Physician informed new order consult with infectious disease doctor. New order .[MEDICATION NAME] (antibiotic) 100 mg (milligrams) BID (twice a day) x 7 days . 6/22/2020 11:22 Health Status Note: Writer received order for stat abdominal x-ray for peg tube placement. Resident currently on ABT (antibiotic therapy) for infection in the site. Feeding stopped due to formula coming from around peg tube . 6/24/2020 17:39 Nutrition/Dietary Note: Follow up visit reveals current route of nutrient administration is compromised AEB (as exhibited by): PEG site infection/malfunction s/s redness, swelling and drainage . 6/24/2020 infectious disease note: .Patient was noted to have redness around PEG site and also leakage. This has progressed over the last 3 or 4 days .Abdomen with significant [DIAGNOSES REDACTED] (skin redness) and induration (from inflammation) around PEG site there is significant also amount of leakage and I understand from the nursing staff that whatever is administered in the PEG tube comes out around it . The progress notes revealed the resident was transferred on 6/25/20 to an acute care hospital for PEG tube replacement. 7/11/2020 15:24 Health Status Note: .Peg tube site continues with drainage site cleaned ABD pad applied . A review of R500's documents from their hospitalization on [DATE] revealed: SNF (skilled nursing facility) to ED (emergency department) Handoff Form, dated 6/25/20 at 11:30 AM signed by Unit Manager K that included, Peg tube malfunction/infection, Reason(s) for transfer: Peg tube replacement - possible hospice w/ (with) terminal wean. IM (internal medicine) History and Physical - Date: 6/26/2020 .admitted : 6/25/2020 .admitted from ECF (extended care facility) for PEG tube malfunction and site infxn (infection) .was unable to receive any po (oral pill form) meds and was hypertensive (had high blood pressure) upon arrival. Infxn (infection) was treated with Doxy at facility .Review of the PEG site raised concern for surrounding [MEDICAL CONDITION] and was started on Vanc ([MEDICATION NAME]) .BP (blood pressure)

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AUTUMN WOODS RESIDENTIAL HLTH	29800 HOOVER RD WARREN, MI 48093

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 0693 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) has been high overnight at times .complaining of pain .Principal Problem: PEG tube malfunction .PEG site infection/[MEDICAL CONDITION]: There is some questionably purulent discharge with surrounding [DIAGNOSES REDACTED] and tenderness around PEG tube .on IV (intravenous) Vanc right now and (superficial cultures) are pending . On 7/16/20 at 8:43 AM, the Director of Nursing (DON) was queried regarding the missing documentation for PEG tube site care on R500's TARs. The DON reviewed R500's TARs for PEG tube site care and stated, There should not be blank spots in the TAR. It should be carried out as ordered. When queried regarding R500's PEG tube site dressing change observed on 7/14/20 with UM K, the DON stated, That is not the expectation. It should not be saturated and not changed. When queried regarding the site having been infected, the DON provided no further information. A review of R500's medical record revealed that the resident was admitted into the facility on [DATE] and most recently re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was moderately cognitively impaired and required total assistance from staff for bed mobility, transfers, dressing, toileting and hygiene. R509 On 07/16/20 a review of the clinical record for R509 revealed: R509 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS dated [DATE] indicated severely impaired cognition and total dependence on one or two persons for Activities of Daily Living including eating. A review of the Treatment Administration Records revealed: For July 2020: Change PEG site dressing every shift and as needed and monitor of signs and symptoms of infection. Start date 06/24/20. The treatment was not documented as done (left blank) for the afternoon shift on 7/1, 7/2, 7/4, 7/6, 7/8, 7/12 and 7/13; For May 2020: Change PEG site dressing every shift and as needed and monitor of signs and symptoms of infection. Start date 04/13/20. The treatment was not documented as done (left blank) for the afternoon shift on 5/1, 5/2, 5/3, 5/6, 5/7, 5/11, 5/13, 5/14, 5/15, 5/17, 5/18, 5/22, 5/25, 5/28, 5/29, 5/30, 5/31; For April 2020: Change PEG site dressing every shift and as needed and monitor of signs and symptoms of infection. Start date 04/13/20. The treatment was not documented as done (left blank) for the afternoon shift on 4/15, 4/20, 4/21, 4/25, 4/27 and 4/29. A review of the facility's policies titled, Tube Feedings, and Enteral Tube Feedings and Medication Administration, reviewed/revised 9/19, did not reveal instructions specific to PEG tube site care and dressing changes. A review of the facility's policy titled, Preventative Skin Care and Documentation, dated 9/19, did not reveal instructions specific to PEG tube site care and dressing changes.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 6. Based on interview and record review, the facility failed to ensure that nursing staff received training in end of life care, potentially affecting one sampled resident (R514) of two residents reviewed for end of life care and potentially affecting all end of life residents in the facility, resulting in the potential for unmet care needs. Findings include: On 7/14/20 at 1:33 PM, Assistant Director of Nursing (ADON) B was queried regarding end of life care training for nursing staff and indicated that she had no record of staff receiving end of life care training. ADON B stated, I will begin training right away. ADON B stated she was told someone from one of the contracted hospice companies came in and did end of life training, but she was unable to find any evidence of that. On 7/14/20 at 2:15 PM, Licensed Practical Nurse (LPN) N was queried regarding end of life training provided by the facility. LPN N stated she had received no training that covered end of life training. LPN N stated, I have educated myself personally on end of life care. We do get hospice residents here. LPN N stated she currently had a hospice resident on the unit she works, and has cared for them previously at the facility. On 7/15/20 at 11:15 AM, Certified Nursing Assistant (CNA) D was queried on if they had received any end of life care training. CNA D stated, I never had any. On 7/15/20 at 11:20 AM, CNA E was queried on if they had received any end of life care training. CNA E stated, I'm not sure when I had it. On 7/15/20 at 11:25 AM, CNA F was queried on if they had received any end of life care training. CNA F stated, I do not remember. On 7/15/20 at 11:30 AM, CNA G was queried on if they had received any end of life care training. CNA G stated, I received it on 7/14/20. On 7/15/20 at 11:38 AM, CNA H was queried on if they had received any end of life care training. CNA H stated, I received it on 7/14/20. On 7/15/20 at 11:50 AM, R514 was observed in their room in bed with their eyes closed. On 7/15/20 at 12:30 PM, a review of R514's Electronic Health Record (EHR) indicated that they began receiving hospice services on 2/14/20. On 7/16/20 at 8:44 AM, the Director of Nursing (DON) was queried on their expectations for nursing staff training regarding end of life care. The DON stated, I think it's important and should be a standard. On 7/16/20 at 9:30 AM, a review of R514's EHR revealed an admission to the facility on [DATE] and a readmission on 1/9/20 with [DIAGNOSES REDACTED]. R514's most recent Minimum Data Set Assessment ((MDS) dated [DATE], indicated a severely impaired cognition and extensive one person assistance for all Activities of Daily Living (ADLs) other than eating. On 7/16/20 at 1:00 PM, a facility policy titled End of Life Care with no date, was reviewed and this policy revealed that it did not address end of life training for nursing staff.