STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235701	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WILLOWS AT OKEMOS	4830 CENTRAL PARK DRIVE OKEMOS, MI 48864

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to intake MI 3802. Based on interview and record review, the facility failed to provide any documents to the receiving facility when one sampled resident (#4) left the facility and transferred to a local teaching hospital resulting in the receiving hospital with no awareness of care or medications R4 received in the nursing home. Findings include: Resident #4 (R4) was admitted to the facility on [DATE] and discharged to a local teaching hospital on [DATE] per family request and against medical advice as there was no order from the attending physician to discharge the resident from the facility. Her [DIAGNOSES REDACTED]. On 8/12/20, a record review of the progress notes, dated 4/22/20, indicated, when emergency transportation arrived, the nursing staff spent time explaining R4 would not be readmitted unless the hospital provided evidence that R4 had two negative tests for Covid-19. The emergency medical technicians (EMTs) were given report of R4's condition and current status. During this report, the family telephoned and requested that the EMTs delay R4's transfer until a priest arrived and prayed for R4. The EMTs waited and the priest arrived. They all met outside. An RN (unidentified) ran outside to emphasize that the ride to the (local hospital) would be billed to the family. There was no documented evidence that R4 or the family was provided a re-cap of R4's stay or a list of R4's medications. On 8/12/20 at 12:15 PM, Director of Nursing (DON) B was asked for copies of transfer documents sent with R4 when she transferred to the local hospital. DON B stated there probably weren't any but she would check. DON B provided copies of documents which were sent to the local hospital via fax the next day after being requested by the local hospital. When a resident initiates his or her transfer or discharge, the medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or if appropriate his/her representative, containing details of discharge planning, and arrangements for post-discharge care. Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident initiated.
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** This citation refers to Intake MI 592. Based on interview and record review, the facility failed to prevent a pressure wound for one sampled resident (#3) out of one resident reviewed for facility-acquired wounds resulting in R3 being sent to the hospital with a large, unstageable and infected pressure wound. Findings include: Resident #3 (R3) was admitted to the facility on [DATE] and discharged home on[DATE]. Her [DIAGNOSES REDACTED]. The fracture to the left fibula was being treated with a boot to the left foot. R3's Brief Interview for mental Status (BIMS) score was 15 out of a possible 15 points indicating this resident had no concerns with thinking and was her own person when making decisions. On 8/11/20, a record review of R3's electronic medical record (EMR) revealed the following information: a physician's orders [REDACTED]. There was no additional information with the order and it was written into the TAR (treatment administration record) as if the presence of the boot had to be visualized three times a day. On 7/7/20, a note was added to the Medication Administration Record [REDACTED]. There was no evidence in the EMR that an orthopedic physician had been contacted and there was no clarification of the initial order that the boot was to be opened so a skin assessment could be done. On 8/11/20 a record review of an intake received by the State Agency revealed the following information: On 7/28/20, a complaint was received from the local hospital that R3 had been admitted to the hospital and, when the boot to her left lower extremity was removed, R3 had a large infected and unstageable wound covered in black eschar to the sole of her foot and one of her toes looked black. R3 told the hospital staff that the facility did not remove the boot from her foot the entire time she was in the facility in spite of R3 complaining of pain in her toes. On 8/12/20, a record review of the policy titled Guidelines for Weekly Skin Observation, policy approval dates of 8/1/16 and 1/7/19, documented the purpose of the policy was to monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated. Under the headline Procedure, item number 1 stated A full body observation shall be completed weekly by the licensed nurse. Item number 6 stated In addition to the Weekly observation by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified. On 8/12/20 at 10:30 AM, an interview with complainant (C) N occurred via the telephone. According to C N, R3 was discharged home on[DATE]. However, early on 7/26 at 4:00 AM, R3 woke up and complained of severe pain in her left foot. R3 was taken to the emergency room at a local hospital and, when the boot to her left foot was removed, it was discovered R3 had a large, infected, unstageable pressure wound to the sole of the foot. On 8/12/20 at 2:30 PM, MDS (Minimum Data Set) Registered Nurse (RN) F was interviewed. RN F wrote the initial and comprehensive care plans for the residents in the facility. When asked if R3 had any skin issues, RN F said No wounds that I'm aware of. On 8/12/20 at 3:00 PM, RN G was asked about foot care for diabetic residents. According to RN G, for a diabetic resident, it was very important to check a resident's feet if they have diabetes. You must remove a boot to check the skin. When asked if she removed R3's boot, she said there was no order to remove the boot. RN G stated no one checked with a physician to see why the staff couldn't remove R3's boot. On 8/12/20 at 3:30 PM, Certified Nursing Assistant (CENA) H was interviewed. CENA H stated she had cared for R3 and had never seen a nurse remove the boot from her left foot to check her skin. On 8/13/20 at 11:30 AM, in an interview with RN I, she stated that the admitting physician would be responsible for writing orders to remove the boot to check the skin on R3's left foot. On 8/13/20 at 1:15 PM, RN K was interviewed by phone. RN K stated she did not check R3's skin under her boot. On 8/13/20 at 4:30 PM, in an interview with Licensed Practical Nurse (LPN) L, she stated the facility policy stated the nurses should check the skin under R3's boot. On 8/14/20, a record review of the emergency room notes revealed, on 7/26/20, R3 had [DIAGNOSES REDACTED] (redness, a sign of infection) streaking up her left leg to mid-calf. Nurse Practitioner (NP) O documented, after assessing the wound,, the impression was that R3 had an unstageable pressure injury to the left foot and [MEDICAL CONDITION] (infection) to the left lower extremity. R3 was started on antibiotic therapy.

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.