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 _____	08/10/2020

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 -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Citation pertains to intake MI 015. Based on observation, interview, and record review, the facility failed to provide activity of daily living care per the resident's preferred preferences for one resident (R609) of four residents reviewed for preferences for activities of daily living, resulting in a formal complaint to the State Agency, dissatisfaction with care, and the potential for discomfort, poor personal hygiene, and embarrassment. Findings include: On 8/4/20 at 2:50 PM, R609 was observed in their room in bed. R609 did not verbally respond to attempts at communication, but was observed to nod, shake their head, or gesture appropriately when asked simple questions. A follow-up interview as conducted with R609 on 8/5/20 at 4:00 PM. During the interview R609 did verbally respond to some questions. R609 was asked about their preference regarding a shower versus a bed bath. R609 indicated they preferred a shower by nodding, said water and made a gesture of washing their hair. At the end of the interview, R609 was queried again about their preference of a shower over a bed bath and said, shower. On 8/4/20 a review of the facility provided shower schedule was conducted and indicated that residents were to receive twice weekly showers and they were scheduled upon the resident's room assignment. A review of R609's clinical record was conducted on 8/4/20 and 8/6/20 and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R609's most recent Minimum Data Set assessment dated [DATE] was conducted and revealed moderately impaired cognition, and extensive to total assistance of one to two staff members for all activities of daily living. A review of R609's Certified Nursing Assistant tasks starting 6/30/20 thru 8/5/20 for whether the resident received a bath, shower, or bed bath was conducted and revealed the following: 6/30/20, R609 received a shower, but did not receive another shower until 7/6/20. 7/13/20, R609 received a shower and was not given any type of bathing until 7/20/20 when they received a bed bath. As of 8/5/20, R609 had not been given a shower since the last documented one on 7/13/20. On 8/6/20 at 11:00 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding resident's preferences regarding baths, bed baths, or showers. The DON indicated residents were assessed for their preferences and should have their preferences honored. When queried specifically regarding R609's preferences, the DON indicated their knowledge that R609 always preferred a shower to a bed bath and should have been given them as scheduled. A review of a facility provided document titled, Rights of Residents in (State name redacted) Nursing Facilities was conducted and read, .You have the right to be treated with respect and dignity, including: .c. The right to reside and receive services in the facility with reasonable accommodation of you needs and preferences except when to do so would endanger the health or safety of the resident or other residents .You have the right to, and the facility must promote and facilitate, resident self determination through support of resident choice, including but not limited to: a. The right to choose activities, schedules .health care and providers of health care services consistent with your interests, assessments, plan of care and other applicable provisions. b. The right to make choices about aspects of your life in the facility that are significant to you . 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 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 citaiton pertains to intake #MI 601 Based on observation, interview, and record review, the facility failed to ensure accommodation of needs for coordinated communication between residents in the facility, and their family members/loved ones during the COVID-19 pandemic for one resident (R604), of one resident reviewed for accommodation of needs, resulting in a formal complaint to the State Agency, feelings of frustration, and the potential for the feelings of sadness, lonliness, isolation, and depression. Findings include: On 8/5/20 at 11:00 AM, a telephone interview was conducted with the complainant. They indicated they had not been able to speak with their loved one during the COVID-19 pandemic. They indicated they had called the facility and spoke to the Director of Nursing (DON), (who was no longer the DON at the time of the survey) and verbalized some concerns regarding R604's care and the ability to either visit R604 from the window, or coordinate some type of tele-conference in order to see and speak to R604. During the interview, the complainant indicated a nursing staff member had given them their personal phone number to call regarding any concerns, and this staff member had told them the tablets the facility used to coordinate the communication were broken. The complainant further indicated that after speaking to the DON and the Staff Member who had given them their phone number, still no one had reached out to coordinate any type of communication. On 8/5/20 at approximately 11:15 AM, an interview with the facility's DON was conducted regarding how the facility coordinated communication between residents and family/loved ones, and they indicated they used electronic applications on smart phones or tablets. When asked which staff or departments were responsible, the DON indicated both the Social Work and Activities Staff were responsible for the coordination of the communication. At that time, the DON was requested to provide evidence from Social Work that coordination for communication had been facilitated for R604 and their loved one. Evidence that the Social Work Department facilitated communication was not provided by the end of the survey. On 8/5/20 at 11:30 AM, an interview with the facility's Activities Director was conducted regarding the coordination of communication for residents and their loved ones and where they would document attempts or evidence of communication. The Activity Director indicated a progress note would be put in the resident's chart. At that time, the Activity Director was queried if they were aware of any attempts to facilitate communication for R604. The Activity Director indicated they had not done it themselves and said, I don't know if I have it. The Activity Director continued to explain that R604 could have gotten lost in the shuffle, but if any staff were aware of any concerns from family/loved ones, they should report it to her so she could coordinate it. On 8/5/20 at 12:30 PM, R604 was observed in their room seated in the wheelchair, watching television. At that time, an interview with R604 was conducted. R604 was asked the last time she had spoken to her family/loved ones and said, A long time. When asked if she would be interested, or if she would like to to see them either through a phone, tablet, or window visit, R604's eyes lit up, they smiled, and vigorously nodded their head. A review of R604's clinical record was conducted and revealed an admission date of [DATE] and a re-admission date of [DATE] with [DIAGNOSES REDACTED]. A review of 604's most recent Minimum Data Set assessment dated [DATE] was conducted and revealed R604 had moderately impaired cognition, was non-ambulatory, and required extensive assistance of one staff member for activities of daily living. The facility was asked if they had a policy regarding coordination of care for communication with family/loved ones during the COVID-19 pandemic and indicated they did not, however; a facility letter that went out to residents and families was provided. The letter was reviewed and read, To Our Residents and Family members .Resident safety is our top priority. We are doing everything we can to ensure we stop the spread of COVID-19 with (facility name redacted) .We are not permitting visitiors per the direction of the local health deparment .We encourage you to call our center at (phone number redacted) for updates on the status of your loved one .We also understand that

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) connecting with family members is incredibly important to our residents. Family members are encouraged to connect with their loved ones through video chat, calling, texting, or other social media formats . 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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** The citation pertains to intake #MI 4 Based on interview and record review, the facility failed to notify the physician of a clinical change in condition for one resident, (R603) of four residents reviewed for change in condition, resulting in R603 running a fever for multiple days and not having fever reducing medications ordered or administered. Findings include: On 8/6/20 at 9:20 AM, a review of R603's closed clinical record was conducted and revealed an admission date of [DATE] and re-admission date of [DATE] with [DIAGNOSES REDACTED]. R603's most recent Minimum Data Set assessment dated [DATE] was reviewed and revealed R603 had severe cognitive impairment, was non-ambulatory, and required extensive assistance of one to two staff members for activities of daily living. A review of R603's progress notes was conducted and revealed they had been discharged to the emergency roiagnom on [DATE]. Continued review of R603's record revealed the following temperatures obtained between 4/1/20 and 4/7/20: 4/1/20 at 5:26 PM--99.3F (Fahrenheit) 4/2/20 at 7:28 AM--100.5F 4/3/20 at 1:25 PM--101.3F 4/4/20 at 11:23 AM--101.0F 4/4/20 at 9:38 PM--102.2F 4/5/20 at 4:52 PM--100.0F 4/6/20 at 3:17 PM--99.1F 4/7/20 at 12:32 AM--102.6F A review of R603's physician's orders [REDACTED]. On 8/6/20 at 11:00 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding when staff should administer medications for a resident running a fever. The DON said that if a resident has a temperature greater than 99.0F, then the nurses should either get an order for [REDACTED]. A review of a facility policy titled, CHANGE OF CONDITION-RESIDENT PHYSICIAN/NP NOTIFICATION with a revision date of 10/29/14 was conducted and read, POLICY: The attending physician/physician extender or on-call physician/physician extender will be notified with changes in a resident's condition or health status . 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 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 717 Based on interview and record review, the facility failed to prevent misappropriation of resident property for one resident, (R607) of four residents reviewed for abuse, resulting in the disappearance of 29 [MEDICATION NAME] (narcotic pain medication) tablets. Findings include: On 8/6/20, a review of a facility reported incident investigation file for missing narcotic pain medications for R607 was conducted. The file contained an unsigned, undated, typed document that read, 5 Day Investigative Findings: (R607) is a resident at (facility name redacted). (R607) resides on 2 North (room #, bed # redacted). (R607) was first admitted on [DATE] .[MEDICATION NAME] (narcotic pain medication) (29 tablets) was reported missing by staff and an investigation was initiated immediately .Facility wide audit completed to ensure no further concerns. No further concerns identified. Licensed nurse education initiated on shift to shift reconciliation conducted. Nurses assigned to (R607) during the time the medication reported as missing interviewed by the Director of Nursing and Assistant Director of Nursing. All 3 nurses requested to submit a urine drug screen by Human Resource Department. 2 nurses tested negative for illicit drugs and 1 nurse refused to comply. Nurse who refused was reported to the state licensing board per protocol and verbally resigned her position at this facility. In conclusion, (R607) sustained no ill effects from the missing PRN (as needed) medication. Licensing board and pharmacy notified. Medication reordered. Abuse cannot be substantiated because 2 nurses tested negative for illicit drugs. Another nurse denied any misappropriation and refused to be tested for any illicit drugs. The same nurse verbally resigned her position at the facility when further questioned about the medication . Continued review of the file included an e-mail dated 6/4/20 from Unit Manager 'I' that read, Subject: Count Discrepancy (Nurse 'J') asked writer to count the 2 north Cart with her so she could go home. (Nurse 'K') was running late. Writer counted with (Nurse 'J') the count was off. Writer told (Nurse 'J') to figure out what was wrong. (Nurse 'K') arrived and counted with (Nurse 'J') . The file contained a signed written statement from Nurse 'H' on 5/28/20 that read, On May 22 I counted the 2N Long cart controlled medications with (Nurse 'J') At the time of the count I told her that I had moved 1 full card from the full inventory to the partial inventory cards. The card was for (R607)'s [MEDICATION NAME]. The inventory was accurate and accepted by (Nurse 'J') . Further review of the file included a document titled Controlled Medications Shift Change Sign out Sheet that was utilized to count the the number of full medication cards, partial medication cards, and had columns to add full cards from pharmacy to the inventory and subtract the number of discontinued cards that had been removed from the inventory on the cart. The card also contained two columns for a signature of the outgoing nurse and a signature of the oncoming nurse to sign after a complete count of the narcotic medications was conducted. Review of this document was conducted and it was discovered that on 5/22/20 on the 3PM-11PM shift, Nurse 'J' signed the line for the outgoing nurse and the line for the oncoming nurse was left blank. The line indicated there were 17 full cards and the number of partial cards was not legible. A line was drawn through the entire entry on the form. The next line on the form was dated 5/22/20 3PM-11PM. The number of full cards column and number of partial cards column was not legible. Nurse 'J' had signed the line for the outgoing nurse and the line for incoming nurse. Next to Nurse 'J's name on the incoming nurse line, there was a slash and a signature from Nurse 'K'. The next line of the form dated 5/23/20 at 7AM had a signature from Nurse 'K' as the outgoing nurse, and the incoming nurse line had error written in it. A line was drawn through the entire entry. The last line on the form was dated 5/23/20 at 7AM and indicated Nurse 'K' was the outgoing nurse and Nurse 'O' was the incoming nurse. It was unclear from the form when the discrepancy was actually discovered, by whom, and how the narcotic count sheet had been adjusted to show that one missing medication. On 8/5/20 at 1:00 PM, a phone call was placed to Nurse 'K', however it was not answered or returned by the end of the survey. On 8/6/20 at 1:10 PM, an interview with the facility's Director of Nursing (DON) was conducted. During the interview they indicated they were not the DON at the time of the incident, rather they were in the position of Assistant Director of Nursing (ADON) and they assisted the previous DON with the investigation. When queried how the incident summarized in the 5 day Investigative Findings was not ruled as misappropriation,when the medications were missing and never recovered, and whether a negative drug screen meant the medications had not been misappropriated, the DON agreed regarding the drug screens and they disagreed with the former DON's statement in the 5 Day Investigative Findings, and indicated it was misappropriation. On 8/10/20 at 9:35 AM, a phone call was placed to Unit Manager 'I', however it was not answered or returned by the end of the survey. On 8/10/20 at 9:40 AM, an interview with the facility's Administrator was conducted regarding the missing medications. The Administrator indicated they did not conduct the investigation and it had all been handled by the former DON. A review of a facility provided policy titled, ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY revised 12/10/18 was conducted and read, POLICY STATEMENT 1. (Corporation Name) will not tolerate verbal, sexual, physical or mental abuse, involuntary seclusion and/or neglect of its resident s or misappropriation of resident's funds or property by anyone . he facility was asked if they had any additional information to provide regarding the concern, none was received by the end of the survey.
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 43 Based on interview and record review, the facility failed to ensure freedom from physical restraints for one resident, (R603) of four residents reviewed for abuse, resulting in the resident being physically restrained during activity of daily living care, and the potential for anxiety, increased behaviors, and injury. Findings include: On 8/5/20 a review of a facility reported incident file was conducted. The file contained a typed document signed by the facility's Administrator that read, .On Friday, March 13, 2020 (R603) informed the Afternoon Nurse Manager that he was jumped by two (2) CENA's (nurse aides). That one held his arm and the other hit him several times . I interviewed (R603) who stated that two CENAs had jumped him and hit him several times. He stated that they were trying to change him that night. He stated that he did need his brief changed .Nurse (L) stated that she was going down 1 North hall to check on a resident. As she entered (R603)'s room, (R603) called out to her saying she hit me .Resident stated he was hit in both arms .came out to interview (R603). During the interview (R603) stated that he was fighting with the CENAs

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F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) because he didn't know what the CENAs were doing .CENA (W) stated that CENA (X) and I entered (R603)'s room to clean him up. When they began to move the covers he began to yell at us and swing his arms. We told him we just wanted to clean him up (CENA 'W') stated she held his arm from swinging so that (CENA 'X') could clean him up .Once finished that's when (R603) made the allegation that (CENA 'X') hit him .CENA ('X') stated that CENA ('W') and I attempted care on R603). When I pulled his covers back, he swung and hit me. I stepped back and told him that's not right to hit and we have to change him . A review of CENA 'W's signed, written statement in the file was conducted and read, On Friday 3/13/20 (CENA 'X') and myself entered (R603)'s room (# redacted) to clean him up. As we started to remove the covers he begin <sic> to yell at us and swing his arms. We both told him that wasn't nice and we just wanted to clean him up. I (CENA 'W') held his arm from swinging so that (CENA 'X') could clean him up .Once we got done that is when the allegation that (CENA 'X') hit him. A review of a written, signed statement by Nurse 'L' was conducted and read, While writer and charge nurse began skin assessment, writer asked resident to tell us what happened. Resident said they both hit me, when asked who, he said 'the little one held my hand while the big one hit me.' Charge nurse asked how many times he was hit. he replied 'several' . A review of R603's clinical record was conducted and revealed an admission date of [DATE] and re-admission date of [DATE]. R603's [DIAGNOSES REDACTED]. A review of R603's most recent Minimum Data Set assessment dated [DATE] indicated severe cognitive impairment, no presence of hallucinations, delusions, behaviors, or rejection of care. Continued review of the assessment indicated R603 was non-ambulatory, required extensive assistance of one to two staff members for activities of daily living, and had bowel and bladder incontinence. On 8/6/20 at 11:00 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding R603. The DON indicated that when R603 first came to the facility (in 2016) they exhibited some adjustment difficulties and exhibited some anxious, verbal, and impulsive behaviors, but since they moved them to a different unit, the behaviors had improved. The DON indicated R603 was very particular about their caregivers. When queried about how CENA's should react when a resident is resistive to care the DON explained they should leave them alone, let the nurse know, and re-approach them, they should not continue. On 8/6/20 at approximately 3:00 PM, the DON provided two signed records for in-service education signed by CNA 'W' and CNA 'X', that read, 1. OBJECTIVE: Approach and Sensitivity. METHOD OF TRAINING: 1-1 Review of Policies: How you approach, a person is the most important factor in determining how the person will respond to you. People of all type and medically/physical concerns especially with dementia/Alzheimer, often have severe cognitive deficits, but are still quite able to recognize and react to emotions. Hence, they will respond to your emotional tone even if they cannot understand what you are saying. When you display impatience and irritation, those feelings will be imparted to the resident, and he or she will respond in return. Approach a person slowly, from the front and with a positive, friendly attitude. Do not take negative response personally and do not over react <sic> to unusual behavior. Be responsive and not reactive . On 8/10/20 at 9:40 AM, an interview with the facility's Administrator was conducted regarding the incident involving R603, CNA 'W', and CNA 'X'. The Administrator was asked about CNA 'W's statement that indicated she held his arms while CNA 'X' continued to clean him up. The Administrator explained that sometimes the witness statements don't articulate well in writing, the Police were not able to substantiate the incident, and (R603) recanted the allegation to the Police. A review of a facility provided policy titled, Restraints dated July 1, 2008 was reviewed and read, PURPOSE: Restraints to be used for the safety and well-being of residents and only after other alternatives have been unsuccessful. PROCEDURE: .3. Restraints not to be used as punishment, convenience of staff or as a substitute for supervision . The facility was asked if they had any additional documentation 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 intake #MI 717. Based on interview and record review, the facility failed to provide evidence of a thorough investigation for missing narcotic medications for one resident, (R607) of four residents reviewed for abuse, resulting in the potential for future occurrences of narcotic medication diversion. Findings include: On 8/6/20, a review of a facility reported incident investigation file for missing narcotic pain medications for R607 was conducted. The file contained an unsigned, undated, typed document that read, (R607) is a resident at (facility name redacted). (R607) resides on 2 North (room #, bed # redacted). (R607) was first admitted on [DATE] .[MEDICATION NAME] (narcotic pain medication) (29 tablets) was reported missing by staff and an investigation was initiated immediately .Facility wide audit completed to ensure no further concerns. No further concerns identified. Licensed nurse education initiated on shift to shift reconciliation conducted. Nurses assigned to (R607) during the time the medication reported as missing interviewed by the Director of Nursing and Assistant Director of Nursing. All 3 nurses requested to submit a urine drug screen by Human Resource Department. 2 nurses tested negative for illicit drugs and 1 nurse refused to comply. Nurse who refused was reported to the state licensing board per protocol and verbally resigned her position at this facility. In conclusion, (R607) sustained no ill effects from the missing PRN (as needed) medication. Licensing board and pharmacy notified. Medication reordered. Abuse cannot be substantiated because 2 nurses tested negative for illicit drugs. Another nurse denied any misappropriation and refused to be tested for any illicit drugs. The same nurse verbally resigned her position at the facility when further questioned about the medication . Continued review of the file included an e-mail dated 6/4/20 from Unit Manager 'I' that read, Subject: Count Discrepancy (Nurse 'J') asked writer to count the 2 north Cart with her so she could go home. (Nurse 'K') was running late. Writer counted with (Nurse 'J') the count was off. Writer told (Nurse 'J') to figure out what was wrong. (Nurse 'K') arrived and counted with (Nurse 'J') . The file contained a signed written statement from Nurse 'H' on 5/28/20 that read, On May 22 I counted the 2N Long cart controlled medications with (Nurse 'J') At the time of the count I told her that I had moved 1 full card from the full inventory to the partial inventory cards. The card was for (R607) [MEDICATION NAME]. The inventory was accurate and accepted by (Nurse 'J') Further review of the file included a document titled Controlled Medications Shift Change Sign out Sheet that was utilized to count the the number of full medication cards, partial medication cards, and had columns to add full cards from pharmacy to the inventory and subtract the number of discontinued cards that had been removed from the supply on the cart. The card also contained two columns for a signature of the outgoing nurse and a signature of the oncoming nurse to sign after a complete count of the narcotic medications was conducted. Review of this document was conducted and it was discovered that on 5/22/20 on the 3PM-11PM shift, Nurse 'J' signed the line for the outgoing nurse and the line for the oncoming nurse was left blank. The line indicated there were 17 full cards and the number of partial cards was not legible. A line was drawn through the entire entry on the form. 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It was further noted the file did not contain any statements/interviews, or attempts at obtaining statements/interviews from Nurse 'J', nor did the investigation file contain any statements/interviews from Nurse 'K' who had signed for the keys from Nurse 'J' on 5/22/20, and had also signed off as the outgoing nurse on 5/23/20 with no incoming nurses signature, but where 'error' had been written in the line for the incoming nurses signature. There was no interview/statement with Nurse 'O' who took the cart from Nurse 'K' on 5/23/20. There was not evidence of statements/interviews with R607, or any other residents in the building. The file did not include any evidence that all of the facility's narcotics were counted, and accounted for, or that education had been given. On 8/5/20 at 1:00 PM, a phone call was placed to Nurse 'K', however it was not answered or returned by the end of the survey. On 8/6/20 at 1:10 PM, an interview with the facility's Director of Nursing (DON) was conducted. During the interview they indicated they were not the DON at the time of the incident, rather they were in the position of Assistant Director of Nursing (ADON) and they assisted the previous DON with the investigation. When queried about the lack of witness statements/interviews from nurses involved in the incident, or other residents, evidence of the full facility audit for all narcotic counts, and evidence of education to the staff, the DON chose not to comment on the former DON's investigation. The DON did however indicate that on 5/22/20 at 11PM, when Unit Manager 'I' first noticed the discrepancy in the narcotic count, it should have been reported and the investigation should have started right then. Unit Manager 'I' should not have passed off the count to Nurse 'K' when Unit Manager 'I' was the first to discover the discrepancy. On 8/10/20 at 9:35 AM, a phone call was placed to Unit Manager 'I', however it was not answered or returned by the end of the

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) survey. On 8/10/20 at 9:40 AM, an interview with the facility's Administrator was conducted regarding the investigation. The Administrator indicated they did not conduct the investigation and it had all been handled by the former DON. A review of a facility provided policy titled, ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY revised 12/10/18 was conducted and read, .e). INVESTIGATION i) Time Frame for Investigation (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident .ii) Investigation Protocol (1) As part of the investigation, the Administrator, and his/her designee, shall take the following action: (a) Interview the resident, the accused (if employee, suspend until investigation complete), and all witnesses. Witnesses shall include anyone who 91) witnessed or heard the incident; (2) came in close contact with either the resident the day of the incident (including other residents, family members, etc.); (3) employees who worked closely with the accused employee(s) and or/alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated . The facility was asked if they had any additional information to provide regarding the concern, none was received by the end of the survey.
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 had two deficient practices. Deficient Practice #1 The citation pertains to intake #MI 4 Based on interview and record review, the facility failed to administer fever reducing medications to one residents (R606) of two residents reviewed for medication administration, resulting in the potential for discomfort and complications of untreated febrile episodes. Findings include: On 8/5/20 at 3:10 PM, a review of R606's closed clinical record was conducted and revealed an admission date of [DATE], a re-admission date of [DATE], and a discharge to the hospital on [DATE]. R606's [DIAGNOSES REDACTED]. A review of R606's most recent Minimum Data Set assessment dated [DATE] was reviewed and revealed R606 had severely impaired cognition, was non-ambulatory and required extensive assistance from one staff person for activities of daily living. A review of R606's physicians orders revealed an order for [REDACTED].'s Medication Administration Records was conducted and did not reveal R606 had been medicated with the as needed [MEDICATION NAME] at, or near the times of the fevers. On 8/6/20 at 11:00 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding when staff should administer medications for a resident running a fever. The DON said that if a resident has a temperature greater than 99.0F, then the nurses should either get an order for [REDACTED]. Deficient Practice #2 This citation pertains to intake #MI 4 Based on interview and record review, the facility failed to coordinate the return of resident belongings after discharge to the hospital for one resident (R606), of one resident reviewed for personal belongings, resulting in a formal complaint to the State Agency and feelings of sadness and disappointment. Findings include: On 8/5/20 at 2:45 PM, an interview with the complainant was conducted. The complainant indicated that R606 had discharged from the facility to the hospital and did not return to the facility. The complainant indicated the facility had not contacted them to coordinate the return of R606's personal belongings, and they were upset. A review of R606's closed clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of R606's progress notes was conducted and revealed they had been transferred out to the hospital on [DATE]. Further review of R606's clinical record included a scanned document that listed an inventory of R606's personal belongings upon admission. Belongings noted on the inventory list were as follows: one blouse, one coat, one hat, one jacket, one pair of shoes, two pairs of slacks, one pair of socks, two sweaters, a cell phone, upper and lower dentures, and a Grand Pad electronic tablet with a red case and black stand. The inventory list had one signature from Social Worker 'BB' in the On Admission section of the form. It was noted on the top of the form there was a section to mark what belongings were returned upon discharge. The form had a line for a signature that read, I received on discharge in satisfactory condition the above articles and a copy of this list. This section on the form did not list any belongings returned and was not signed. On 8/6/20 at 9:15 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding the facility's process of returning resident belongings when they transfer out of the facility and do not return. The DON explained that when a resident goes to the hospital, Admissions Director 'G' follows up with the hospital, the resident, and or the family to see if they will return to the facility. At that time, if they weren't returning, Admissions Director 'G' would coordinate the return of the belongings. When asked how it would be documented that belongings were returned to either the resident or the family, the DON indicated the resident's inventory list would be compared with the belongings returned and whoever received the belongings back would sign-off on the list that they received them. On 8/6/20 at 9:45 AM, an interview with Admissions Director 'G' was conducted. Admissions Director 'G' was asked if they reached out to R606 or their family after their discharge from the facility. The Director indicated they attempted to call R606's first contact listed on their face sheet and stated, No one returned my call. When asked if they left a voice mail or a message for the person they called, the Director said they didn't recall. Finally, the Director was asked if she kept any type of log that showed she reached out to residents or families and indicated she did not keep a log. The facility was asked for a policy regarding the return of resident belongings after discharge, and the DON indicated they didn't have a specific policy, and they used the inventory sheets.
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 accurate narcotic reconciliation counts for one resident, (R607) of one resident reviewed for pharmacy services, resulting in 29 missing [MEDICATION NAME] pills (narcotic pain medication) and the potential for future narcotic diversion. Findings include: A facility reported incident was received by the State Agency that indicated R607 had 29 tablets of [MEDICATION NAME] come up missing. On 8/6/20, a review of a facility reported incident investigation file for missing narcotic pain medications for R607 was conducted. The file contained a document titled, Controlled Medications Shift Change Sign Out Sheet. A review of the sheet revealed columns for the date, the shift, the number of narcotic cards (the card dispensed from the pharmacy that houses each individual pill in a blister pack) received from the pharmacy, the number of empty or discontinued narcotic cards to be returned to the Director of Nursing, the total number of full cards, the total number of partial cards, and the total number of narcotic cards stored in the medication cart. The sheet also had a column for a signature from the outgoing nurse and a column for a signature of the oncoming nurse. Continued review of the sheet revealed the following: On 5/14/20 for the 11P-7A shift the sheet indicated there were 16 full cards and 18 partial cards for a total of 34. On 5/14/20 there was not an entry for the 7AM-3PM shift and the next entry on the form dated 5/14/20, 3PM-11PM documented no cards received from pharmacy, no cards discontinued, 18 full cards, 18 partial cards for a total of 36. On 5/16/20 at 3PM, there was no signature for the oncoming nurse. On 5/18/20 at 7AM the sheet indicated there were 16 full cards and 17 partial cards for a total of 33. For the 3PM-11PM shift no cards were received from the pharmacy, no cards were discontinued, but the count was documented at 17 full cards and 18 partial cards for a total of 35, two more than the previous shift. On 5/18/20 for the 11PM-7AM shift the sheet documented 2 cards received from pharmacy and 2 cards discontinued. It was documented that now there were still 17 full cards, but only 16 partial cards that totaled 33, but the column for the total was noted to be left blank. On 5/19/20 for 3PM-11PM no cards were added, no cards were discontinued and numbers were now 18 full cards and 17 partial cards for a total of 35. It was noted the numbers for full and partial cards on this entry appeared to have been changed having been written over in darker ink. It could not be made out what the original number documented for full cards was, but it could be made out that number of partial cards had been changed from 16 to 17. On 5/22/20 at 7AM the form documented 17 full cards and 18 partial cards for a total of 35. The next entry on the form dated 5/22/20, (the time was not legible) documented 18 full cards, and 17 partial cards, but none were either received from the pharmacy or discontinued. On 5/22/20 for the 3PM-11PM shift, a discrepancy between the documentation and the amount of narcotics was noted by Unit Manger 'I' and the outgoing nurse, Nurse 'J'. This had been reported to the State Agency as a Facility Reported Incident. Nurse 'J' signed the line for the outgoing nurse and the line for the oncoming nurse was left blank. on 5/22/20 for the 3PM-11PM shift. The line indicated there were 17 full cards and the number of partial cards was not legible. A line was drawn through the entire entry on the form. The next line on the form was dated 5/22/20 3PM-11PM. The number of full cards column and number of partial cards column was not legible. Nurse 'J' had signed the line for the outgoing nurse and the line for

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	235320	A. BUILDING _____ B. WING _____	08/10/2020

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

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) incoming nurse. Next to Nurse 'J's name on the incoming nurse line, there was a slash and a signature from Nurse 'K'. The next line of the form dated 5/23/20 at 7AM had a signature from Nurse 'K' as the outgoing nurse, and the incoming nurse line had error written in it. A line was drawn through the entire entry. The last line on the form was dated 5/23/20 at 7AM and indicated Nurse 'K' was the outgoing nurse and Nurse 'O' was the incoming nurse. It was unclear from the form when the discrepancy was actually discovered, by whom, and how the narcotic count sheet had been adjusted to show the one missing medication card. On 8/10/20 at approximately 11:00 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding the discrepancies on the Controlled Medications Shift Change Sign Out Sheet. The DON reviewed the sheet and explained that she didn't know how the counts could go up or down if nothing was received from the pharmacy, or nothing had been discontinued. The DON had also been aware of the discrepancy on 5/22/20 that resulted in a missing card of [MEDICATION NAME] for R607 and had worked with the previous DON on that investigation. A review of a facility provided policy titled,Medication Administration Controlled Substances dated 2007 was conducted and read, PROCEDURES .2. The Director of Nursing and the Consultant Pharmacist establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled .7. At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record. The facility was asked if they had any additional information to provide; none was received by the end of the survey.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 4, MI 9, and MI 5: Based on observation, interview, and record review the facility failed to ensure staff utilized appropriate personal protective equipment (PPE) for residents on droplet precautions, ensure appropriate hand hygiene was performed, failed to distinguish residents admitted from the hospital under observation for signs and symptoms of COVID-19 from residents who resided in the facility who had exposure to COVID-19 by a staff member, and ensure consistent signage was present to indicate the use of droplet precautions during the COVID-19 pandemic. This deficient practice affected all 83 residents who resided in the facility, resulting in the potential for the spread of infection, and the potential for unnecessary prolonged isolation. Findings include: On 8/4/20 at approximately 1:10 PM, entry to the building to begin the abbreviated survey occurred and screening was performed by Staff member 'AA' in the front lobby. At that time, Staff 'AA' was queried what type of face mask the facility required for entry. They indicated that a KN95 mask and goggles or a face shield was required. On 8/4/20 at 3:51PM, the DON was asked what guidance they used to determine their infection control practices and indicated they used the CDC (Centers for Disease Control and Prevention) guidelines. The DON was queried with regards to droplet precautions at the facility and per the DON, 83 of 83 residents were on droplet precautions related to their exposure to an employee who had tested positive for COVID-19. The DON explained all residents in the facility at the time of the exposure to the COVID-19 positive staff member went on, Complete Monitoring. When queried what was meant by Complete Monitoring, the DON explained that all 83 residents in the facility were placed on droplet isolation precautions, and were being assessed for signs and symptoms of COVID-19. The DON was further queried if residents on Complete Monitoring were treated with the same infection control principles as residents that were new admissions from the hospital and indicated they were, but there were designated areas on the 1 South and the 1 North unit for the hospital admissions. The DON was then asked if the same PPE was used for residents on Complete Monitoring and new admissions from the hospital and indicated it was. Finally, the DON was asked, if at the time of the staff member's positive COVID-19 test, if all staff had been wearing KN95 masks and indicated they had. On 8/4/20 at 1:20PM the facility's Director of Nursing (DON) acknowledged there were no residents positive for COVID-19 at the facility. At that time, it was observed staff were dressed in all types of PPE, including KN95 masks, re-usable gowns, and face shields or goggles. An interview with the DON was conducted regarding the staff's use of PPE up and down the hallways on the 1 North unit and the DON referred to tape lines marking the floor to indicate certain areas of the facility where personal protective equipment was being utilized for resident care areas. A bin was observed for clean, re-usable gowns near the nurses desk/elevator lobby area by the 1 North unit and a bin for dirty gowns was observed by the entry to the 1 North unit. On 8/4/20 from approximately 2:30 PM until 2:45 PM, observations were made of the front lobby, the 1 North nursing station, and the 1 North unit. The following was observed: Some resident rooms on 1 North had signs on the door to indicate monitoring room and droplet precautions, some resident rooms had no signage on the door to indicate the use of precautions for the resident, and a few rooms were observed to have PPE kits present on the outside of the resident room doors. A resident was observed to be in the hallway of the 1 North unit by the nurse's cart and a music speaker. Staff member 'Q' was observed to enter the 1 North nursing station area from the lobby with a KN95 face mask on their face, however; they were not using the elastic head straps to keep the mask in place, they were holding the mask to their face with their hands. Staff 'Q' exited the building through a side door off the 1 North unit. Therapy Staff member 'R' was observed from the hallway to be working with a resident in their room on the 1 North Unit. Staff member 'R' had on an isolation gown, a KN95 face mask and face shield, but was not observed to be wearing gloves. Therapy Staff member 'S' was observed from the hallway working with a resident in their room. Staff member 'S' was observed to be wearing an isolation gown and KN95 mask. Staff 'S' was not observed to be wearing a face shield, goggles, or gloves. Staff 'S' briefly exited the room to the hallway. Staff 'S' was not observed to perform hand hygiene prior to or after exiting the room. After their exit, Staff 'S' re-entered the room and began working with the resident. Staff 'S' was not observed to don a face shield, goggles, or gloves upon re-entry to the room. On 8/4/20 from 2:55 PM until 3:10 PM, an observation of the 2nd Floor unlocked, Nursing Unit was conducted, the following was observed: Certified Nurse Aide (CNA) 'N' and CNA 'T' were observed in the hallway completing their CNA charting at the kiosk on the wall. CNA 'N's KN95 face mask was observed over their mouth and chin, but was not covering their nose. CNA 'T' was not observed to be wearing a face shield or goggles. Nurse 'U' was observed in the hallway at the medication cart. Nurse 'U' was not observed to be wearing a face shield or goggles. Nurse 'H' was observed to enter a resident's room. Nurse 'H' was not observed to be wearing a face shield or goggles prior to, or upon entering the room. Nurse 'H' was also not observed to don gloves upon entering the room. On 8/4/20 at 3:51PM, an interview was conducted with the DON regarding multiple aspects of the facility's infection control practices. The DON was asked what guidance they used to determine their infection control practices and indicated they used the CDC (Centers for Disease Control and Prevention) guidelines. The DON was queried with regards to droplet precautions at the facility and per the DON, 83 of 83 residents were on droplet precautions related to their exposure to an employee who had tested positive for COVID-19. The DON explained all residents in the facility at the time of the exposure to the COVID-19 positive staff member went on, Complete Monitoring. When queried what was meant by Complete Monitoring, the DON explained that all 83 residents in the facility were placed on droplet isolation precautions, and were being assessed for signs and symptoms of COVID-19. The DON was further queried if residents on Complete Monitoring were treated with the same infection control principles as residents that were new admissions from the hospital and indicated they were, but there were designated areas on the 1 South and the 1 North unit for the hospital admissions. The DON was then asked if the same PPE was used for residents on Complete Monitoring and new admissions from the hospital and indicated it was. Finally, the DON was asked, if at the time of the staff member's positive COVID-19 test, if all staff had been wearing KN95 masks and indicated they had. The DON was asked what guidance they used to place all 83 residents on droplet isolation precautions related to their exposure to a COVID-19 positive staff member, and the DON indicated they used CDC guidance. The DON was queried in regard to some residents having PPE storage kits on the resident room doors, and explained that right now there should be none on the door. Per the DON, the facility did have some residents on droplet precautions for 14 days after admission from the hospital that had a PPE storage kit, but explained their 14 days had reset, because of the exposure to the COVID-19 positive staff member. When queried as to how a CNA would know a resident was a new admission from the hospital requiring observation versus a resident potentially exposed to COVID-19 from an employee, the DON explained it would not be something the CNA would know. The DON was next asked what PPE staff were supposed to wear when a resident was on droplet precautions, and said staff were to wear an isolation gown, a KN95 mask, and a face shield or goggles. The DON was asked if prescription eyeglasses were an acceptable alternative to a face shield or goggles, and indicated they were not. When queried about the use of gloves in a resident's room who is under Complete Monitoring or droplet isolation precautions, the DON indicated gloves only needed to be worn if staff were giving direct care. As the interview continued, the DON was queried about residents who were on droplet precautions having been observed in the hallway and common areas. The DON explained that as much as possible residents were not supposed to be in common areas, and they would be given a mask to come to the hallway

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) and wear in the hallway. On 8/5/20 at approximately 8:10 AM, upon entry to the building, screening was being performed by Staff 'P'. Staff 'P' was not observed to instruct an authorized non-staff visitor to change from a surgical mask to a KN95 mask. On 8/5/20, at approximately 8:20 AM, it was brought to the DON's attention that Staff 'P' did not instruct the authorized non-staff visitor to don a KN95 mask and the DON indicated they would educate Staff 'P'. On 8/10/20 at 10:04AM Infection Control Nurse 'Z' was queried about droplet precautions, and explained that a mask, goggles, and gown would be worn. When queried if staff should wear gloves while in a resident room where the resident is on droplet precautions, Infection Control Nurse 'Z' responded absoutely. Provided by the facility was a document titled Droplet Precautions, undated, (source CDC on bottom of page) which documented, Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking .-Source Control: put a mask on the patient, -Ensure appropriate patient placement in a single room if possible In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives .-Use personal protective equipment (PPE) appropriately. Don mask upon entry into the patient room or patient space . A policy on Transmission Based Precautions was requested from the facility, and no policy was provided as it was explained by the DON that the facility followed CDC guidelines. Review of the CDC Clinical Questions about COVID-19: Questions and Answers updated August 4,20 revealed, in part, the following question: A healthcare provider at our facility was recently diagnosed with [REDACTED].? The response to the question documented, in part, Anyone who had prolonged close contact (within 6 feet for at least 15 minutes) with the infected healthcare provider might have been exposed .Recommended actions for HCP, patients, and visitors .Place exposed patients who are currently admitted to the healthcare facility in appropriate Transmission-Based Precautions and monitor them for onset of COVID-19 until 14 days after their last exposure .