STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235033	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAY BLUFFS-EMMET CO MED CARE FAC	750 E MAIN HARBOR SPRINGS, MI 49740

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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** Based on observation, interview, and record review, the facility failed to ensure staff assisted a one Resident (#84) in a timely manner to maintain their dignity out of 22 residents reviewed for dignity. This deficient practice resulted in a Resident being left to wait for assistance and the potential for further skin breakdown. Findings include: On 3/12/20 at 9:49 a.m., Resident #84's call light was observed to be on (lit up) in the hallway with the door to her room open. Resident #84 was observed lying in her bed with her eyes closed repeatedly pressing on her call light. At 9:53 a.m., Certified Nurse Aide (CNA) C and CNA D were observed in the dining room closest to Resident #84's room putting trays into a tray cart and pouring juices. An unidentified staff was overheard stating in the dining room, I better go turn that light off. At 9:55 a.m., CNA C was observed going into Resident #84's room, asked her what she needed, took the call light out of the Residents hand and set it on the bed beside her, and turned the call light off. Resident #84 stated to CNA C, Change my pants! CNA C then stated to Resident #84, We'll be back. On 3/12/20 at 9:56 a.m., CNA C was interviewed about the observations described above. When asked what assistance Resident #84 had requested, CNA C stated, To be cleaned up. When asked if she had turned the call light off before completing the Residents' request, CNA C stated, Yeah. When asked if it was normal practice to shut the call light off prior to completing the requested care, and CNA C stated, Yes. It's not like I was neglecting her. When asked why she had not left the call light on so it would alert another staff who was free to help the Resident, CNA C stated (CNA D) already knows she (Resident #84) wants to get cleaned up. I need her help to change her and we were getting someone else up. I put her (Resident #84) down (in bed) around 9:15 (a.m.) When asked if Resident #84 had requested to be cleaned up at that time, CNA C stated, Yeah. On 3/12/20 atapproximately 9:58 a.m., CNA C and CNA D were observed standing in small dining room near Resident #84's room whispering to each other with their arms crossed. On 3/12/20 at 9:59 a.m., the door of Resident #84's room was closed and care was being provided. On 3/12/20 at approximately 10:10 a.m., the Director of Nursing (DON) was notified of the interview and observation of Resident #84's call light and care request not being addressed timely. The DON provided no comment. A review of Resident #84's medical record revealed she admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 2/11/20 Minimum Data Set (MDS) assessment revealed she scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating moderately impaired cognition and required extensive assistance of one staff for toileting. A review of a 3/12/20 progress note for Resident #84 revealed, Resident has 2 stage pressure sores with red wound bed measuring .5 cm (centimeters) x .5 cm and .6 cm .5 cm surround peri wound is denuded . This indicates that the Resident already had pressure breakdown and was at risk for further breakdown. A review of the facility policy titled, Call Light Accessibility and Response updated 1/7/20 revealed, .8. Process for responding to call lights .F. if assistance is needed with a procedure, summon help by using the call light. Stay with the Resident until help arrives .
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on interview and record review, the facility failed to ensure that written notifications of transfer were provided to the Resident, Resident Representative, and the Ombudsman for four Residents (#9, #69, #72, #96) out of five residents reviewed for hospitalization notifications. This deficient practice resulted in the potential for lack of awareness for transfers. Findings include: Resident #96 A review of Resident #96's record revealed he admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 2/19/20 Minimum Data Set (MDS) assessment revealed he was assessed by staff to be severely cognitively impaired. A review of a Facility Reported Incident (FRI) investigation for Resident #96 revealed he was transferred to the Emergency Department on 3/4/20 for X-rays after being found on the floor unwitnessed. On 3/11/20 at 3:36 p.m., the Nursing Home Administrator (NHA) was asked to provide evidence that written notification of the transfer was sent to the family. The NHA stated, We did not do one for (Resident #96). Because we sent him for X-rays we didn't know we needed to do one. Previously were were only verbally telling the families and documenting the reason for transfer in their medical record. A review of the facility policy titled, Transfer/Discharge Notice reviewed 2/20/19 revealed, .3 The Resident and/or Representative (sponsor) will be notified in writing of the following information: a) The reason for the transfer or discharge. b) effective date of the transfer or discharge; c) The location to which the Resident is being transferred or discharged . Resident #69 On 03/11/20 at 10:05 AM, an interview with Resident #69 revealed the following: I had two hospitalization s. Both times I was there about 4 days . A review of the face sheet for Resident #69 revealed admission to the facility on [DATE]. A review of the MDS assessment for Resident #69 dated 1/29/20 revealed a Brief Interview for Mental Status (BIMS) assessment of 15, indicating intact cognition. A review of the MDS assessment section of the Electronic Medical Record (EMR) revealed two discharge assessments dated 11/18/19 and 11/24/19, indicating Resident #69 went to an acute care hospital setting. The EMR and physical chart were reviewed. There was no evidence of written notification to Resident #69 and resident representative for either discharge to the hospital. On 3/11/20 at 10:30 AM an interview with the Director of Nursing (DON) revealed Resident # 69 was sent to the hospital on [DATE] and 11/24/19 per the DON . for an infected boil which lead [MEDICAL CONDITION]. A review of a History & Physical document for Resident #69 dated 11/24/19 revealed the following: (Resident #69) was recently discharged from (local hospital) that was on November 21. (Resident #69) was treated for [REDACTED]. On 3/11/20 at 12:30 PM, evidence of written notification to resident/resident representative for two discharges to an acute care hospital was requested. No evidence of written notification to resident/resident representative for hospitalization s on 11/18/19 and 11/24/19 were provided by the facility. On 3/12/20 at 12:10 PM, an interview with the DON revealed the following: (Resident # 69) does have a nurses notes stating (Resident #69) went out to the hospital, but we have not been doing written notifications. Resident #72 On 03/10/20 at 4:49 PM, an interview with Resident #72 revealed the following: I went back to the hospital after a fall, and I broke my hip. A review of the face sheet for Resident #72 revealed admission to the facility on [DATE]. A review of the MDS assessment for Resident #72 dated 1/28/20 revealed a BIMS assessment of 7, indicating moderately impaired cognition. A review of the MDS assessment section of the EMR revealed discharge assessments dated 11/1/19 and 1/16/20 indicating Resident #69 went to an acute care hospital setting. The EMR and physical chart were reviewed. There was no evidence of written notification to Resident #72 and resident representative for either discharge to the hospital. A review of an unwitnessed fall incident dated 1/16/20

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

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) revealed Resident #72 went to the hospital on [DATE] after a fall resulting in a suspected fracture. (Resident #72) complained of right hip pain and it was noted that (Resident #72)'s right leg was externally rotated . (Physician A) notified and order received to transport (Resident #72) to (local hospital) ER for evaluation. On 3/11/20 at 12:30 PM, evidence of written notification to resident/resident representative for two discharges to an acute care hospital was requested. No evidence of written notification to resident/resident representative for hospitalization s on 11/18/19 and 11/24/19 were provided by the facility. On 3/12/20 at 12:10 PM, an interview with the DON revealed the following: (Resident #72) does have a nurses note stating (Resident #72) went out to the hospital, but we have not been doing written notifications. Resident #9 A review of the MDS assessment for Resident #9, dated 12/3/19, revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #9 was assessed as severely cognitively impaired. On 3/10/20 at 2:36 p.m., a review of a progress note, dated [DATE] at 1:38 p.m., revealed Resident #9 had been transferred to the emergency department on [DATE] at 1:30 p.m., for evaluation after a fall. Further review of the EMR and physical chart revealed no written notification of the transfer to the resident or their family. On 3/12/20 at 8:25 a.m., an interview with the NHA confirmed Resident #9 had been transferred to the emergency department on [DATE]. The NHA reported the facility had not sent the required documentation notifying Resident #9 or Resident #9's family of the transfer. On 3/12/20 at 8:45 a.m., a review of the ombudsman notifications for February 2020, revealed the ombudsman had not been notified of Resident #9's transfer to the emergency department on [DATE].
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain safety equipment in functional condition for 1 Resident #65) of 7 residents reviewed for accidents/hazards. This deficient practice resulted in the potential for falls, and subsequent injury. Findings include: Resident #65 On 3/10/20 at 11:44 AM, Resident #65 was observed to have an auto brake safety device attached to the frame of the wheelchair for safety. The bars of the mechanism (intended to make contact with wheels when Resident #65 rose from the wheelchair or self transfered from another surface to the wheelchair) were observed to be out of alignment. Resident #65 was laying in bed during this observation, and the hand brakes of the wheelchair were released to test the functionality of the auto brake safety device. The mechanism bars did not make contact with wheels. The wheelchair moved freely back and forth during this test. This potentially placed Resident #65 at risk of falling and injury if Resident #65 were to rise from the wheelchair, or transfer from another surface to the wheelchair without engaging the hand brakes. On 3/10/20 at 2:12 PM, an interview with Resident #65 revealed the following: I had really bad fall at home where I hit my head, just before I came here. Resident #65 explained this was the reason for being hospitalized and subsequently for being at the facility. A review of the face sheet (printed 3/12/20) for Resident #65 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Morse Fall Scale assessment dated [DATE] revealed a score of 65, indicating Resident #65 was a high risk for falls. A review of the care plan for ADL (Activities of Daily Living) self care deficit for Resident #65 with a review date of 2/14/20, revealed the following intervention: Locomotion: I have a manual w/c (wheelchair) that I am able to propel . My w/c is equipped with auto brakes for safety. A review of the kardex (care delivery guide) for Resident #65 with a printed date of 3/12/20 revealed under Mobility, My w/c is equipped with auto brakes for safety. A review of a Restorative Progress Note dated 2/3/20 at (2:27 PM) revealed . Resident (#65) frequently observed self-transferring in room: onto toilet and in/out of bed . Wheelchair is equipped with auto brakes for safety, no falls since admission to the facility . A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 required limited one person physical assistance for transfers, and extensive one person physical assistance for toileting. On 3/11/20 at 1:29 PM, there was an additional observation of the auto brake safety device being out of alignment and not functioning effectively. On 3/12/20 at 1:50 PM, there was an additional observation of the auto brake safety device being out of alignment and not functioning effectively. On 3/12/20 at 1:55 PM, an interview with Maintenance Director G revealed the following: When shown the condition of the auto brake safety device, Maintenance Director G stated, Yeah, that's (auto brake safety device attached to wheelchair of Resident #65) definitely not going to work. On 3/12/20 at 2:15 PM, an interview with the Director of Nursing (DON) regarding Resident #65 and the use of an auto brake safety device revealed the following: When asked about why the auto brake safety device was being used for Resident #65 with no history of falls since admission to the facility, the DON stated, (Resident #65) has a tendency to self transfer.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure oxygen supplies were dated appropriately for 1 Resident (#18) of 1 resident reviewed for oxygen services. This deficient practice resulted in the potential for respiratory infections related to the potential for use of oxygen supplies beyond normal use time frames. Findings include: Resident #18 On 3/10/20 at 12:15 PM, Resident #18 was noted to be on an oxygen concentrator and the concentrator was set at 3 liters per nasal cannula (oxygen tubing delivery device), and the nasal cannula was in place on Resident #18. The nasal cannula and humidification chamber were observed undated. A review of the face sheet for Resident #18 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS) assessment section O dated 12/6/19 revealed Resident #18 had been receiving oxygen therapy at the facility. On 3/11/20 at 1:35 PM, an additional observation of the nasal cannula and humidification chamber providing Resident #18 with oxygen was not dated. There was also an additional nasal cannula connected to the portable oxygen tank on the back of Resident #18's wheelchair which was not dated. On 03/12/20 at 2:00 PM, an additional observation was made with Licensed Practical Nurse (LPN) H of the undated nasal cannula and humidification chamber providing Resident #18 with oxygen. LPN H was asked if the nasal cannula and humidification chamber should be dated. LPN H stated, Yes it is but I do not know how it is done on the night shift. LPN H stated to ask Registered Nurse (RN) I because she had just switched to days from the midnight shift. On 3/12/20 at 2:03 PM, an interview with RN I revealed the following: The oxygen tubing is changed and dated by the oxygen company, I think on Monday nights. On 3/12/20 at 2:15 PM an interview with the Director of Nursing (DON) revealed oxygen tubing and humidification chambers are dated and changed out weekly by (contracted oxygen services company). The DON acknowledged the nasal cannula and humidification chamber should have been dated by the oxygen services company. A facility policy for oxygen was requested from the DON. No Oxygen services Policy was provided by the end of the survey.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** Based on interview and record review, the facility failed to ensure that Certified Nurse Aides' (CNA) Annual competencies were being completed to identify individualized education needs. This deficient practice resulted in the potential for lack of care and inability to meet Resident needs and has the potential to effect all Residents. Findings include: On 3/12/20 at 10:49 a.m., CNA Competency and In-service hours were reviewed with Human Resources/Staff E. When asked to provide the CNA competencies, Staff E provided a document titled 2019 Annual Clinical Skills Fair which included six topics but did not clearly show the different competencies required of CNAs to perform their job duties. Staff E showed this Surveyor the competency for the job duties is used upon hire of CNAs, but reported that this form is not used for the annual reviews as they do the skills fair instead. On 3/12/20 at 1:45 p.m., an interview was conducted with the Administrator about the lack of annual comprehensive CNA competencies. The Administrator reported that they do the skills fair yearly. When asked why the Competency only included certain topics, the Administrator reported that those were the areas the facility identified to be issues of concern. When asked why the CNAs were not being reviewed to see if they were competent in areas like 'Eating assistance' or 'Call Light answering', the Administrator stated, Because we didn't identify those to be facility issues. The facility was not assessing each CNA to ensure that they were competent on CNA specific duties to identify education needs. On 3/12/20 at 3:33 p.m., the Administrator reported that they were not doing competency checks for disease specific concerns, and that moving forward they would be doing comprehensive competency evaluations to identify individual areas of weakness prior to issues occurring.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.**

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a medication error rate below 5% for two Residents (#55 & #59) of five residents reviewed for medication administration. This deficient practice resulted in the potential for undesirable or inadequate therapeutic effect of prescribed medications. Findings include: On 3/11/20 at 7:16 AM, Registered Nurse (RN) J was observed administering medications to Resident # 55. [MEDICATION NAME] (steroidal nasal spray) 50 mcg (micrograms)/actuation (delivery), two sprays in each nare were administered to Resident #55. During the administration, the bottle was tipped up past horizontal and air could be heard along with partial administration of the medication. When asked if RN J could hear the sound of air mixing with the liquid medication as it was being administered to Resident #55, and Resident #55 was not receiving the full spray, RN J stated Yes. When this Surveyor pointed out the bottle position was allowing the fluid in the bottle to fall away from the straw pulling up the medication for delivery, and putting air into the applicator, RN J stated, Thank you for letting me know. On 3/11/20 at 8:48 AM, RN I was observed administering medications to Resident # 59. RN I administered both [MED] (short-acting [MED]) 100 units/ml (milliliter) - 8 units, and [MEDICATION NAME] (long-acting [MED]) 100 units/ml - 50 units. RN I was observed rubbing the injection sites immediately following the injection of the above [MED] medications. When asked why this action was done, RN I stated, That was how I was taught in nursing school. On 3/12/20 at 7:55 AM, an interview with Administrator revealed the following: We don't have a ([MED] administration) policy yet, but after this one (reported medication administration incident) we are in the process of developing one . A review of the facility policy Administering Medications with a review date of 3/7/20 revealed no specific guidance for [MED] administration steps or technique. A review of Lippincott Manual of Nursing Practice, 8th edition, provided by the facility, page 722 revealed under Administering the subcutaneous injection: Insert the needle quickly in one motion . Inject the medication . Remove the needle gently but quickly at the same angle inserted . Don't massage the site. A review of the website at https://www.healthline.com/health/diabetes/[MED]-injection (accessed on 3/13/20 at 3:05 PM) read in part: . Step 10. Release the pinched skin immediately after you've pushed the plunger down and removed the needle. Don't rub the injection site. You may notice minor bleeding after the injection. If so, apply light pressure to the area with gauze and cover it with a bandage if necessary .
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI Intake: #MI 728 Based on interview, and record review, the facility failed to prevent a significant medication error for one Resident (#71) of three residents reviewed for insulin administration. This deficient practice resulted in the potential for diabetic [DIAGNOSES REDACTED] (a serious medical condition from low blood sugar including possible [MEDICAL CONDITION], unconsciousness or death). Findings include: A review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #71 revealed a [DIAGNOSES REDACTED]. Resident #71 received insulin injections for all seven days in the look back period for this assessment and scored a 12/15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitve impairment. A review of the electronic medication record for Resident #71 revealed physician orders [REDACTED]. (to) Resident (#71) . (Resident #71) currently has long and short-acting insulin doses to assist in managing his blood sugars . On February 25, 2020 (Registered Nurse (RN) F) self-reported a medication error in administering the wrong insulin to (Resident #71) during the PM med pass .In order to address the system failure that led to this incident, the DON (Director of Nursing) interviewed the nurse to determine exactly how the wrong insulin was administered. The nurse verbalized that there were two vials of (name brand fast- acting insulin) and one vial of (long-acting insulin) in the resident medication cubby in the medication cart. The nurse assumed that the vial he picked up was the long-acting insulin as it was in the opposite cubby as the short-acting. He realized only after administering (the insulin) that the vials were not in the correct locations. The nurse has been counseled on his error . The counseling memorandum written by the DON was reviewed and included: (RN F) administered a short acting insulin (name brand) vs (verses) a long acting insulin (name brand) to a resident (#71). This error could of (sic) cause the resident harm. On 03/12/20 at 8:09AM, RN F stated in a phone interview that he had mixed up the viles of insulin and had given the wrong type of insulin to Resident #71. On 03/12/20 at 07:55 AM, the Nursing Home Administrator (NHA) stated the facility did not have a policy specific to insulin administration at this time. A policy titled Administering Medications dated as reviewed 03/07/2020 stated in part: The individual administering the medication must check the label THREE (3) times to verify the right Resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 3/12/20 at 9:18AM, the NHA observed the plan of care for Resident #71 and stated there was not a diabetes management care plan for this resident at this time.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly dispose of a controlled substance anti-anxiety medication in one of three medication carts reviewed for medication storage. This deficient practice resulted in the potential for contamination of medication and drug diversion. Findings include: On 3/12/20 at 2:56 p.m., a review of a medication cart located on the Lilac Wing, with Registered Nurse (RN) B, revealed a blister pack of [MEDICATION NAME] (a controlled substance anti-anxiety medication) 0.5 milligram (mg) tablets, prescribed to Resident #12. Upon pulling the medication pack from the locked drawer of the medication cart, RN B reported the card was unopened. Further inspection of the medication pack revealed one of the blisters holding medication had been broken open and resealed with tape. RN B reported she was unsure of why the blister had been taped after opening. RN B reported medications should not be replaced once removed. When asked what the facility's procedure was regarding controlled-substances, RN B reported the medication should have been disposed of and not replaced in the opened blister pack. An interview with the DON, on 3/12/20 at 3:00 p.m., revealed the facility's policy regarding disposal of unused medications had not been followed. When asked if staff should reseal a medication pack after opening, the DON replied, No, (they are) not supposed to do that. A review of the policy titled, General Guidelines for Medication Storage, dated 6/21/17, revealed the following, in part: Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier . Procedure . 11. Outdate, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy .