STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235664	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIDGE SOUTH HEALTHCARE CTR	18200 W 13 MILE ROAD BEVERLY HILLS, MI 48025

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #s: MI 897 and MI 421. Based on interview and record review, the facility failed to ensure the resident's responsible party/legal representative was notified of a change in condition (fall) for one (R708) of three residents reviewed for notification of changes in condition, resulting in the responsible party/legal representatives not being notified of changes in condition. Findings include: A review of multiple complaints reported to the State Agency included allegations that responsible parties were not being notified of changes in residents' condition. On 7/28/20, an unannounced, onsite investigation was conducted. A review of the clinical record revealed R708 was admitted into the facility on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented R708 as severely cognitively impaired, and had one fall without injury since the previous MDS assessment dated [DATE]. On 7/28/20 at 11:35 AM, the Director of Nursing (DON) provided documentation of R708's falls since January 2020, which included three fall incidents on: 4/14/20, 5/15/20, and 6/1/20. Upon review of this documentation with the DON, when asked what the facility's process was for notifying resident's responsible party following any fall incidents, the DON reported staff should call the responsible party and document that information on the incident report or in the progress notes. The DON further reported there should have been an SBAR (Situation, Background, Assessment, and Recommendation) assessment completed for the fall on 4/14/20, which had not been completed. At that time, the DON was requested to review R708's fall incident report from 4/14/20 and confirmed there was no documentation that the responsible party had been contacted. The DON was requested to provide a facility policy to address notification of change in condition. A review of the facility's Changes in Resident Condition policy dated February 2017 documented, in part: .the resident's legal representative are notified when changes in the resident's condition occur .The SBAR communication Form and the Progress Note are used to .Provide clear comprehensive documentation .
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** This citation pertains to intake #MI 701. Based on observation, interview and record review, the facility failed to ensure timely/completed assessments and investigations into falls, and identify and implement appropriate fall interventions for one (R708) of three residents reviewed for falls, resulting in continued falls and the increased potentials for falls with serious harm and/or injury. Findings include: A review of complaints reported to the State Agency included allegations that residents were falling due to lack of adequate staffing. On 7/28/20, an unannounced, onsite investigation was conducted. On 7/28/20 at 1:40 PM and 7/29/20 at 9:45 AM, R708 was observed lying in bed, asleep and did not awaken upon approach. A review of the clinical record revealed R708 was admitted into the facility on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented R708 as severely cognitively impaired, exhibited no behaviors, required extensive assistance of one person for bed mobility, transfers and toilet use, and had one fall without injury since the previous MDS assessment dated [DATE]. A review of the fall risk assessments dated 4/16/20 and 7/16/20 revealed R708 was a high risk for falls. A review of the fall care plan documented, I am at risk for Falls 2/2 (secondary to) history of falls, decreased safety awareness, [MEDICAL CONDITION], dementia, at times I choose to not wait for staff to assist me with ambulating. This care plan had been initiated on 1/24/19, and last revised 3/19/20. There were no new fall interventions identified since 2019. On 7/28/20 at 11:35 AM, the Director of Nursing (DON) provided documentation of R708's falls since January 2020, which included three fall incidents on: 4/14/20, 5/15/20, and 6/1/20. Upon review of this documentation with the DON, there were incomplete and missing documentation to identify what the facility had investigated into the circumstances of the falls, and what interventions had been implemented to prevent continued falls. When asked what the facility's process was for reviewing fall incidents, the DON reported documentation would be completed by the interdisciplinary team (IDT) after a fall. At that time, the DON was requested to provide any additional documentation for R708 to be able to review what the facility had reviewed, monitored, and implemented to prevent further fall incidents. Review of the fall documentation for 4/14/20 at 5:45 PM revealed R708 had been found on the floor in the room resting on the right side. The notes section of the incident report read, Resident attempted to go to the rest room with out assistance, after having Midline (an intravenous catheter inserted into a peripheral vein used to administer fluids or medication) placed to the upper right arm and for got <sic> to take the pole. No injuries noted/observed. X-ray ordered for (blank - there was no further documentation) .Resident had new midline placed today and forgot to bring the pole wither <sic> while attempting to go <sic> the bathroom . There was no post fall review included with this fall documentation to indicate whether this fall had been reviewed/discussed with the IDT, or what interventions were implemented to prevent continued falls. There was no radiology report included as well, or available in the clinical record to indicate if the x-ray had been obtained and what the results were. This incident report identified witnesses, but did not include any witness statements. Review of the fall documentation for 5/15/20 at 11:21 AM revealed R708 had been observed sitting on the floor at the foot of the bed facing the doorway with knee up off the floor, and that the resident had been trying to go to the bathroom. The mental status section indicated R708 was oriented to person only, had gait imbalance and weakness. There were no witnesses, and the section for predisposing situation factors was left blank. There was no post fall review included with this fall documentation to indicate whether this fall had been reviewed/discussed with the IDT, or what interventions were implemented to prevent continued falls. Review of the fall documentation for 6/1/20 at 10:54 PM revealed R708 was heard yelling out for help and was noted on the floor. The mental status section indicated R708 was oriented to person only, had gait imbalance, impaired cognitive status, weakness and was confused. There were no witnesses, and the section for predisposing situation factors was left blank. There was no post fall review included with this fall documentation to indicate whether this fall had been reviewed/discussed with the IDT, or what interventions were implemented to prevent continued falls. On 7/28/20 at 12:30 PM, the DON provided post fall documentation for the fall on 5/15/20 and 6/1/20 and reported she was unable to find any other documentation for the fall on 4/14/20. The DON further reported she had not taken over the role of the DON until the first of June and was not the DON at that time. Review of the documentation provided by the DON included: In regards to the fall incident on 5/15/20, a document which read, Interdisciplinary Post Fall Review had been completed on 05/28/2020 12:33 (PM) (13 days following the fall). Documentation included, .Patient none <sic> compliant with uses <sic> of call .Intervention Recommendations .Care Plan Revision .IDT Referrals .Physical Therapy .Occupational Therapy .Can Resident Demonstrate use of Call light in Room .No .

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) This review had been signed by the current DON on 6/5/2020 (20 days following the fall). Review of R708's fall care plan revealed there were no documented care plan revision on the fall care plan since 3/19/20, and no new care plan interventions added since 2019. Review of R708's progress notes included an entry by the Therapy Manager on 5/18/20 at 4:18 PM, which read, .Patient was discharged from skilled PT (Physical Therapy) last week after she reached max rehab potential and not showing any significant decline in activities. She need assistance with transfers for safety and educated the patient to call for help for transfers. Patient agreed with the plan. No PT eval recommended at this time. On 7/29/20 at 9:50 AM, the DON was asked about the facility's process to monitor residents post fall such as neurochecks and where that documentation would be maintained. The DON reported neurochecks were done post falls and reported R708's neurochecks for the falls on 4/14/20, 5/15/20, and 6/1/20 might need to be scanned into the electronic clinical record and would follow up. On 7/29/20 at 11:40 AM, the DON provided neurocheck documentation for R708's fall on 5/15/20 and 6/1/20, but reported she was unable to locate any neurochecks for the fall on 4/14/20. When asked about the recommendation for therapy following the fall on 5/15/20 and upon review of the entry documented by the Therapy Manager, the DON acknowledged the entry and was unable to offer any further explanation as to whether any alternate interventions were attempted given therapy did not recommend services at that time. When asked about whether it would be appropriate to re-educate R708 to utilize the call light for assistance, given the significant cognitive limitations, the DON reported No. The DON was asked about the delay in review of the fall on 5/15/20 and reported the IDT reviewed falls under the Risk manager and at that time, the former DON was responsible for review of the fall on 5/15/20. When asked about the discrepancy in the date of review on 5/28/20 and the current DON's signature on 6/5/20, the DON reported the facility had been trying to catch up. A review of the facility's Fall Management policy dated July 2017 documented, in part: .The Interdisciplinary Team (IDT) evaluates each resident's fall risks. A Care Plan is developed and implemented, based on this evaluation, with ongoing review .When a resident is found on the floor, the facility is obligated to investigate to determine how the resident got there and put into place an intervention to minimize it from recurring .
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number: MI 195 Based on interview and record review, the facility failed to arrange [MEDICAL TREATMENT] transportation for one (R#706) a newly admitted COVID-19 positive [MEDICAL TREATMENT] resident reviewed for [MEDICAL TREATMENT] treatment, the facility was identified as a hub for COVID positive residents being discharged from the community hospitals, resulting in the failure to coordinate and schedule the resident's [MEDICAL TREATMENT] transportation and for the resident to have missed their 5/7/20 [MEDICAL TREATMENT] treatment. Findings include: On 5/8/20 at 11:51 am, the State Agency received a complaint that the facility failed to arrange transportation for [MEDICAL TREATMENT] for R#706 on 5/7/20 resulting in the resident to have missed their [MEDICAL TREATMENT] treatment. A review of R#706's clinical record revealed the following: R#706 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10 (which indicated moderately impaired cognition). R#706 was dependent on staff for most activities of daily living (ADL's). A review of R#706's census documented an admission date of [DATE]. Pre-Admission paperwork dated May 2, 2020 at 4:03 PM, documented in part .Patient has confirmed or suspected COVID-19. Follow appropriate precautions .Pt (patient) is ready for d/c (discharge) - will need transportation to ([MEDICAL TREATMENT] facility name redacted). Pt needs placement while awaiting a negative COVID swab at which time pt will be able to go to her new group home placement . A Nursing Note dated 5/6/20 at 3:40 am, documented in part .Resident newly admitted to facility .Resident is [MEDICAL TREATMENT] patient .[MEDICAL TREATMENT] days Tuesday, Thursday, and Saturday chair time at 6:30 (midnight get up). Resident [MEDICAL TREATMENT] center is ([MEDICAL TREATMENT] facility name redacted) . The next scheduled [MEDICAL TREATMENT] appointment date for R#706 was for 5/7/20 (Thursday). There was no documented note that the resident made it to [MEDICAL TREATMENT] on this day. Communication documentation between the facility and [MEDICAL TREATMENT] center was requested from the Director of Nursing (DON) on 7/28/20 at 3:50 PM and was not provided by the end of survey. A Nursing Note dated 5/8/20 at 14:41 (2:41 PM) documented in part .Resident was admitted to facility. Resident was scheduled for [MEDICAL TREATMENT] and was not reported upon admission. Transportation was not set up resident is scheduled for 5-9-2020 transportation is set up . A Receiving Facility Plan (no date) from the facility's COVID-19 binder, documented in part .We want to be proactive and help our hospital partners as this COVID-19 pandemic gets larger. In order to be able to do that we need to have COVID-19 units established so that we are able to take stable patients from the hospitals into our care .The District, Division and Field Support teams will determine whether residents should be discharged from the originating facility and admitted to the receiving facility. To the extent that a patient(s) are treated as new admissions, admission paperwork will be prepared and the patient(s) will be entered into (name of electronic medical system) .The receiving facility staff will communicate with the staff at the originating facility to determine whether there are special needs that need to be accommodated, such as [MEDICAL TREATMENT], physician, appointments .The receiving facility will determine whether they can accommodate the need as it is currently or whether there is a need to make alternative arrangements. For instance, is the [MEDICAL TREATMENT] center close enough that the patient can continue with the service or does the facility need to make alternative arrangements with a [MEDICAL TREATMENT] center that is located closer to the receiving facility. Arrangement will be made and transportation schedule to meet the needs of the patient, if required . On 7/28/20 at 3:56 PM, the DON was queried on why R#706's transportation to [MEDICAL TREATMENT] was not scheduled for the 5/7/20 [MEDICAL TREATMENT] date and stated in part .Transportation is set up by the hospital and it wasn't set up . When asked if the pre-admission paperwork was reviewed prior to R#706's admission, to be sure that the facility could accommodate the resident needs, the DON stated in part .the admission nurse verifies transportation . When queried on why that wasn't done on admission for R#706, the DON explained that being a hub and in the middle of a pandemic it wasn't an easy situation and also stated .this was a learning lesson for us all . On 7/29/20 at 8:15 am, the facility's policies on [MEDICAL TREATMENT] and [MEDICAL TREATMENT] transportation was requested from the Administrator. The [MEDICAL TREATMENT] policy was reviewed and contained no guidance for staff regarding [MEDICAL TREATMENT] transportation and a policy for [MEDICAL TREATMENT] transportation was not provided by the end of survey.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 897. Based on interview and record review, the facility failed to ensure residents were free from unnecessary [MEDICAL CONDITION] medications for one (R702) of three resident reviewed for unnecessary medications, resulting in the resident remaining on [MEDICAL CONDITION] medication without adequate documentation to justify use of as needed (PRN) medication beyond 14 days, and the increased likelihood of serious side effects and adverse reactions. Findings include: Review of a complaint submitted to the State Agency alleged the facility staff were over sedating the resident. A review of the closed record revealed R702 was originally admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R702 scored 3/15 on the Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Review of R702's physician orders [REDACTED]. Review of the Medication Administration Records (MARs) for R702 revealed: The January 2020 MAR indicated [REDACTED]. These dates were beyond the 14 days from the 12/27/19 start date. The February 2020 MAR indicated [REDACTED]. These dates were beyond the 14 days from the 12/27/19 start date. The March 2020 MAR indicated [REDACTED]. These dates were beyond the 14 days from the 12/27/19 start date. On 7/28/20 at 1:25 PM, an interview was conducted and the Director of Nursing (DON) was asked about Monthly Medications Reviews (MRR's) performed by a pharmacist. The DON explained that prior to 6/1/20, when she became the DON, the recommendations were not available. The DON explained that she and the Consultant Pharmacist tried to go back and get the recommendations, but were unable to get them all. Review of the available pharmacy recommendation revealed on 1/20/20, a Consultant Pharmacist documented, PRN anxiolytic with no stop date. No physician or facility response was documented and the PRN (namebrand of [MEDICATION NAME]) order was

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) continued beyond the 14 days. Review of progress notes did not reveal documentation by a physician for continued use of the PRN [MEDICATION NAME]. On 7/29/20 at 10:17 AM, an interview was conducted and the DON was queried about R702's PRN [MEDICATION NAME] order. The DON explained she was aware of the continuous order for the [MEDICATION NAME]. When asked if she knew how long a PRN order for a [MEDICAL CONDITION] medication could be written for, the DON explained she knew it could only be for 14 days. Review of a facility policy titled, [MEDICAL CONDITION] Management revised November 2017 read in part, .[MEDICAL CONDITION] medication is any medication that affects brain activities associated with mental processes and behavior. These medications include, but are not restricted to the following categories .Anti-anxiety . PRN orders for [MEDICAL CONDITION] medications are limited to 14 days, except as provided by Federal regulation, and cannot be renewed unless the Attending Physician or prescribing Licensed Practitioner evaluates the resident for the appropriateness of that medication. If the Attending Physician or prescribing Licensed Practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order .
F 0777 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure radiology results and recommendations were communicated to, and addressed by the physician/licensed practitioner for one (R708) of three residents reviewed for falls, resulting in the physician/licensed practitioner being unaware of the need for further radiology recommendations and the potential for delay in treatment. Findings include: A review of the clinical record revealed R708 was admitted into the facility on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented R708 as severely cognitively impaired, exhibited no behaviors, required extensive assistance of one person for bed mobility, transfers and toilet use, and had one fall without injury since the previous MDS assessment dated [DATE]. On 7/28/20 at 11:35 AM, the Director of Nursing (DON) provided documentation of R708's falls since January 2020, which included a fall incident on 4/14/20. The documentation provided revealed R708 had been found on the floor in the room resting on the right side. The notes section of the incident report read, Resident attempted to go to the rest room with out assistance, after having Midline (an intravenous catheter inserted into a peripheral vein used to administer fluids or medication) placed to the upper right arm and for got <sic> to take the pole. No injuries noted/observed. X-ray ordered for (blank - there was no further documentation) . There was no radiology report included in this documentation, or available in the clinical record to indicate if the x-ray had been obtained as ordered. A review of the physician/extender progress notes following the fall on 4/14/20 included entries on 4/16/20, 4/21/20, and 4/28/20 which did not address the resident's fall on 4/14/20 or mention a review of any radiology results (only laboratory testing that had been ordered). On 7/29/20 at 9:50 AM, the DON was asked about the lack of the resident's x-ray results which had been ordered on [DATE], and upon review of the resident's electronic medical record (EMR), the DON confirmed there were no radiology results available. At that time, the DON utilized her own computer and reported the x-ray for R708 had been completed on 4/16/20 and results were reported to the facility on [DATE]. The DON was asked if there was any documentation that the physician/licensed practitioner had addressed the recommendation in the radiology report which read, .Advise repeat films when able with special attention to radiographic technique . and the DON reported she would follow up. On 7/29/20 at 11:40 AM, the DON reported I found the radiology report that was provided to the Physician but it's not signed. Didn't put any notes. I spoke with (name of the Physician Assistant B) and confirmed they only addressed the labs ordered, not the x-ray. The DON was unable to offer any further explanation as to the facility's lack of follow up. A review of the facility's Diagnostic Services Management policy November 2017 documented, in part: .Diagnostic testing results are promptly reported to the ordering physician/licensed practitioner in accordance with the physician's/licensed practitioner's orders. Abnormal or results showing critical values are reported immediately to the ordering physician/licensed practitioner .Diagnostic reports are maintained in the resident's medical record .Diagnostic services are defined as any examination or analysis of the body .for purposes of providing information for the diagnosis, prevention or treatment of [REDACTED].