STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235224	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LENAWEE MEDICAL CARE FACILITY	200 SAND CREEK HWY ADRIAN, MI 49221

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake MI 383 Based on observation, interview and record review the facility failed implement care plan interventions for sampled resident (Resident #4), resulting in no assistance with ADL and/or bowel/bladder by nursing staff during third shift, the potential for skin breakdown, worsening of a pressure ulcer, resident's needs to go unmet, discomfort and frustration to a reasonable person. Findings Include: Resident #4 (R4) On 7/23/20 at 12:21 PM R4 was observed in her room. R4 was sitting up in her specialized high back wheelchair, with an elevated padded footrest, where her legs/feet were laying outstretched. Bilateral light blue padded foot coverings were observed on her feet, and she was cleanly clothed. R4 appeared to look around her room aimlessly. A conversation was attempted by writer, R4 looked in writer's direction did not reply, but made incomprehensible sounds. A passerby staff revealed R4 could not respond to writer. The Electronic Medical Record (EMR) for R4 was reviewed at 1:30 PM and reflected she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The most recent quarterly Minimum Data Set (MDS: resident assessment tool) with an Admission Reference Date (ARD) of 5/27/20 reflected R4 was severely cognitively impaired, required extensive to total assistance of 2 persons for bed mobility, transfers, dressing, toilet use, and bathing. Also that R4 required extensive assistance of 1 person for eating and hygiene, had impaired bilateral lower extremities, and two stage 2 pressure ulcers. The MDS reflected pressure ulcer stage 2 as: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. The Director Of Nursing (DON B) was interviewed at 1:59 PM related to the Facility Reported Incident (FRI) provided dated 3/12/20, of R4 not being repositioned by a (Resident Service Aide) RSA. DON B revealed the facility had a video during the time of care, of the incident, and was asked to retrieve it. DON B revealed that RSA C was suspended during the time pending the investigation, and that they had educated and trained her on the process. Prior to exiting the facility's building on 7/23/20 DON B revealed the facility was unable to provide the video of the incident because it was not longer available At 2:02 PM the FRI investigation file was reviewed: The packet reflected the incident took place on 3/12/20 at around 5:15 AM, and reported to the State Agency at 07:47 AM. The facility nurse (Licensed Practical Nurse LPN D), had asked one of her aides (RSA C) if she had repositioned the elder (R4) last night and RSA C replied, I haven't been in there all night. LPN D re-educated RSA C about the importance of repositioning the elder every two hours, that R4's care plan indicated that she was to be turned per facility protocol which was/is every two hours, and RSA C was suspended. The investigation reflected camera footage verified, as did RSA D, that the resident was not turned during third shift on 3/11/20. Also that R4 had wounds on her left heel, right buttock, coccyx and a surgical wound on her back not facility acquired. The wound nurse assessed the resident's wounds on 3/12/20 and noted that the resident's right buttock wound was slightly larger from 1 centimeter (cm) x 1.2 cm to 1 cm x 2 cm. The witness statement dated 3/12/20 at 08:22 AM completed by Registered Nurse (RN E) reflected she interviewed R4's sister (F). When asked if staff checked on or performed care on R4 during the 11 PM - 7 AM shift 3/11/20 - 3/12/20 Sister F stated, I don't believe they came in except around 4 AM to change her dressing. The witness statement dated 3/12/20 at 03:00 PM completed by Registered Nurse (RN E) reflected she interviewed RSA C. When asked if staff checked on R4 third shift from 3/11/20 - 3/12/20 RSA C stated, I visually checked on her, I did not go in the room. When asked if she checked R4's care plan RSA C said, No. The EMR documentation of repositioning reflected R4 was repositioned on 3/11/20 at 10:59 PM and not again until 3/12/20 at 11:47 AM. On 7/24/20 at 1:53 PM LPN D was interviewed by phone and asked to recall the incident dated 3/12/20. LPN D revealed, I had to change the dressing on her (R4) back and she was sweaty on her backside. I asked the RSA if she had re-positioned her, and she said she had not been in there all night. The investigation file reflected LPN D changed R4's dressing at around 04:30 AM. LPN D revealed RSA C had worked with R4 before, that R4's sister had been in the room at the time, and that RSA C had gotten mandated (required to work additional hours), and was there all through second shift and third shift. In addition, R4 had been sleeping while laying on her back, sweaty on her back, she (LPN D) explained to the RSA how important it was to reposition her (R4), and that she (RSA C) knew her and that she (R4) could not move on her own to reposition. I educated her and reported it to my administrator. RSA C received and signed an Employee Final Warning Report on 3/19/20. Under Rules Violated reflected Group 1, #2: Negligent or dangerous act which contributes to a hazard for or injury to any elder, employee or other person on the premises of the Facility. Did not follow the facility policy for putting her eyes on the elder every hours as well as not turning the elder every 2 hours. R4's wounds care plan revised on 3/5/20 reflected: -I need assist with repositioning per protocol. R4's recent hospitalization after fall with back fractures care plan revised on 3/3/20 reflected: -Elimination: check and change per policy. -Elimination: I have a Foley catheter to direct drainage. Provide Foley catheter care AM (morning) / HS (night time) and PRN (as needed) per policy. -Elimination: I wear incontinent products for protection. -Pain: Reposition and use pillows to aid in comfort. -Care Needs: I rely on the staff to anticipate my needs. The Importance of Bed Checks and Hourly Rounding education sheet reflected: It is (name of facility) policy that the RSA's put their eyes on every resident on an hourly basis. The reason for this policy is to ensure our residents are safe and their needs are being met. When done consistently, hourly rounding will: -Reduce resident falls, -Reduce call light use -Reduce skin breakdown -Improve resident perceptions of their care -Help identify resident's who are prone to exit-seeking behaviors Key actions for hourly rounding -If they're unable to reposition themselves, the RSA is to reposition the resident every 2 hours
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake MI 383 Based on observation, interview and record review the facility failed provide Activities of Daily Living (ADL) assistance to 1 sampled resident (Resident #4), resulting in assistance with ADL and/or bowel/bladder not provided, the potential for skin breakdown, worsening of a pressure ulcer, resident's needs to go unmet, discomfort and frustration to a reasonable person. Findings Include: Resident #4 (R4) On 7/23/20 at 12:21 PM R4 was observed in her room. R4 was sitting up in her specialized high back wheelchair, with an elevated padded footrest, where her legs/feet were laying outstretched. Bilateral light blue padded foot coverings were observed on her feet, and she was cleanly clothed. R4 appeared to look around her room aimlessly. A conversation was attempted by writer, R4 looked in writer's direction did not reply, but made incomprehensible sounds. A passerby staff revealed R4 could not respond to writer. The Electronic Medical Record (EMR) for R4 was reviewed at 1:30 PM and reflected she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The most recent quarterly Minimum Data Set (MDS: resident assessment tool) with an

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

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Admission Reference Date (ARD) of 5/27/20 reflected R4 was severely cognitively impaired, required extensive to total assistance of 2 persons for bed mobility, transfers, dressing, toilet use, and bathing. Also that R4 required extensive assistance of 1 person for eating and hygiene, had impaired bilateral lower extremities, and two stage 2 pressure ulcers. The MDS reflected pressure ulcer stage 2 as: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. The Director Of Nursing (DON B) was interviewed at 1:59 PM related to the Facility Reported Incident (FRI) provided dated 3/12/20, of R4 not being repositioned by a (Resident Service Aide) RSA. DON B revealed the facility had a video during the time of care, of the incident, and was asked to retrieve it. DON B revealed that RSA C was suspended during the time pending the investigation, and that they had educated and trained her on the process. Prior to exiting the facility's building on 7/23/20 DON B revealed the facility was unable to provide the video of the incident because it was not longer available. At 2:02 PM the FRI investigation file was reviewed: The packet reflected the incident took place on 3/12/20 at around 5:15 AM, and reported to the State Agency at 07:47 AM. The facility nurse (Licensed Practical Nurse LPN D), had asked one of her aides (RSA C) if she had repositioned the elder (R4) last night and RSA C replied, I haven't been in there all night. LPN D re-educated RSA C about the importance of repositioning the elder every two hours, that R4's care plan indicated that she was to be turned per facility protocol which was/is every two hours, and RSA C was suspended. The investigation reflected camera footage verified, as did RSA D, that the resident was not turned during third shift on 3/11/20. Also that R4 had wounds on her left heel, right buttock, coccyx and a surgical wound on her back not facility acquired. The wound nurse assessed the resident's wounds on 3/12/20 and noted that the resident's right buttock wound was slightly larger from 1 centimeter (cm) x 1.2 cm to 1 cm x 2 cm. The witness statement dated 3/12/20 at 08:22 AM completed by Registered Nurse (RN E) reflected she interviewed R4's sister (F). When asked if staff checked on or performed care on R4 during the 11 PM - 7 AM shift 3/11/20 - 3/12/20 Sister F stated, I don't believe they came in except around 4 AM to change her dressing. The witness statement dated 3/12/20 at 03:00 PM completed by Registered Nurse (RN E) reflected she interviewed RSA C. When asked if staff checked on R4 third shift from 3/11/20 - 3/12/20 RSA C stated, I visually checked on her, I did not go in the room. When asked if she checked R4's care plan RSA C said, No. The EMR documentation of repositioning reflected R4 was repositioned on 3/11/20 at 10:59 PM and not again until 3/12/20 at 11:47 AM. On 7/24/20 at 1:53 PM LPN D was interviewed by phone and asked to recall the incident dated 3/12/20. LPN D revealed, I had to change the dressing on her (R4) back and she was sweaty on her backside. I asked the RSA if she had re-positioned her, and she said she had not been in there all night. The investigation file reflected LPN D changed R4's dressing at around 04:30 AM. LPN D revealed RSA C had worked with R4 before, that R4's sister had been in the room at the time, and that RSA C had gotten mandated (required to work additional hours), and was there all through second shift and third shift. In addition, R4 had been sleeping while laying on her back, sweaty on her back, she (LPN D) explained to the RSA how important it was to reposition her (R4), and that she (RSA C) knew her and that she (R4) could not move on her own to reposition. I educated her and reported it to my administrator. RSA C received and signed an Employee Final Warning Report on 3/19/20. Under Rules Violated reflected Group 1, #2: Negligent or dangerous act which contributes to a hazard for or injury to any elder, employee or other person on the premises of the Facility. Did not follow the facility policy for putting her eyes on the elder every hours as well as not turning the elder every 2 hours.