STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235396	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT SILVERBELL ESTATES	1255 W SILVERBELL RD ORION, MI 48359

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 128: Based on observation, interview, and record review the facility failed to consistently and accurately assess resident skin to promptly identify changes in skin condition, implement timely interventions and treatment after changes in skin were identified, and prevent the development and worsening of pressure ulcers for two (R#804, #805) of three residents reviewed for pressure ulcers, resulting in R#804 developing a wound to the left heel classified by the facility's wound care provider as a deep tissue injury (persistent non-blanchable deep red, maroon, or purple discoloration) and by the facility as an unstageable (obscured full thickness skin and tissue loss) pressure ulcer, and R#805 developing moisture associated skin damage classified by the facility which worsened to a stage III pressure ulcer (Full-thickness loss of skin) classified by the facility's wound care provider. Findings include: R#804: On 8/13/20 at 9:30AM R#804 was observed sitting up to the side of their bed with their dining tray in front of the resident. The resident's bare feet were observed to be resting on the floor of the resident's room. R#804 explained that their left foot was their bad foot, and said their right foot was getting that way too. On 8/13/20 at 11:45AM, R#804's left heel wound was observed with Unit Manager (UM) 'G'. R#804's left heel wound was observed to be black in color, was described as unstageable, and no visible treatment was observed to be present to the resident's left heel wound. The clinical record for R#804 was reviewed and revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's significant change minimum data set (MDS) assessment dated [DATE] documented the resident scored seven out of fifteen on a brief interview for mental status exam, which indicated the resident was severely cognitively impaired. Per this assessment R#804 required the extensive assistance of one person for bed mobility, and the extensive assistance of two plus persons for transfers. Also, per this assessment it was documented the resident was at risk for pressure ulcers/injuries and had one unstageable wound with slough and/or eschar, documented as present on admission, entry, or re-entry per the assessment. However, it was noted that the facility's roster matrix form identified R#804 as having a facility acquired unstageable pressure ulcer. Review of a Skin/Wound Note (Narrative) dated 6/10/20 at 4:16PM documented, in part, .Writer was notified by resident that his heel on his left foot was hurting. Writer assessed and took a picture of the heel. Writer observed heel to be black and boggy Review of a REPORT OF RESIDENT SKIN CONDITION (event date 6/10/20 at 2:30PM) revealed, in part, the following: Resident c/o (complained of) a sore heel. Writer assessed heel and observed a black discoloration to bottom of heel. Resident stated his heel has been hurting for some time. Per the type of skin event, pressure ulcer had been selected. It was documented the resident had a pressure ulcer with the following description: discoloration to L heel accompanied by pain 2/10. The form also documented the following question: Is this skin event a pressure ulcer? Yes, had been selected as the response to the question. Per the form the pressure ulcer had been classified as unstageable, the resident did not have the wound when admitted to the facility, the resident had not had a history of [REDACTED]. Per a physician order [REDACTED].#2 Left Heel is a Deep Tissue Injury and has received a status of Not Healed. Initial wound encounter measurements are 6cm (centimeter) length x 7cm width, with an area of 42 sq (square) cm. Wound bed has Dark Maroon Base [MEDICATION NAME] .Diagnosis.: Deep Tissue Injury L (left) Heel . Continued review of physician orders [REDACTED]. Review of R#804's Medication Administration Record [REDACTED]. Documentation on the MAR pertaining to the orders for application of boots and (Brand Name liquid wound dressing) to the bilateral heels began on 6/10/20. Orders were not observed prior to 6/10/20 on the resident's MAR indicated [REDACTED]. Per an order with a start date of 1/1/20 it was documented, Skin Checks Weekly every evening shift every Wed for Monitoring Complete Skin Observation Evaluation. Review of skin assessments for R#804 revealed R#804 had a Skin Observation evaluation present in the electronic medical record dated 5/13/20 (documented as weekly assessment). The next documented Skin Observation evaluation for R#804 was dated 6/10/20 (type documented as other). Skin Observation evaluations were not observed in the resident's clinical record between the dates of 5/13/20 and 6/10/20. Review of R#804's Skin Observation-V1 assessment dated [DATE] revealed, in part, the following: 1. Does the Resident have ANY Skin Issues Observed? No was selected as a response to the question. Per the body diagram section of the assessment, sites identified did not include the resident's left heel. Per the question, 4. New Wound, Wound Team Evaluation Needed a response was selected to indicate No. Review of R#804's Skin Observation-V1 assessment dated [DATE] revealed, in part, the following: 1. Does the Resident have ANY Skin Issues Observed? Yes was selected as a response to the question. Per the body diagram section of the assessment, the site identified was the left heel, described on the assessment as a deep tissue injury. Per the question, 4. New Wound, Wound Team Evaluation Needed a response was selected to indicate Yes. Review of a plan of care for R#804 dated 6/10/20 documented, Resident has risk of skin impairity <sic>. (Brand Name) boots to be worn at all times. On 8/13/20 at 2:10PM the facility's Director of Nursing (DON) was queried regarding pressure ulcers at the facility. The DON explained the facility had a Wounds on Wednesdays program which consisted of unit managers or other designated nurses taking photos of and evaluating wounds. In addition, weekly head to toe skin assessments would be completed by the nurses. The DON explained the wound care Nurse Practitioner (NP) came on Fridays. When queried as to how a resident would be seen by the wound practitioner, the DON explained if there was skin breakdown, a change in skin condition, or skin integrity concerns upon admission then the resident would be placed on wound rounds, the nurse would communicate with the unit manager, the Unit manager would notify the wound Nurse Practitioner, then it would be at their discretion. When queried as to what staff were to do if they noticed a new area on a resident's skin, the DON explained treatment would be put in place, the Unit Manager would be notified, a photograph would be taken of the wound, the resident would be referred to wound care, and notifications would be made. When queried as to who was able to stage and measure pressure ulcers at the facility, the DON responded any nurse trained on measuring and those trained on (facility wound program name) could complete the photos. Per the DON when staff took the photo that nurse would complete the staging, and RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) could stage. The DON explained the facility had an algorithm that would be recommended to the physician pertaining to treatment. The DON explained an incident report and progress note would be completed if a change in skin condition was identified. When queried who was responsible for ensuring skin assessments were being completed, the DON responded this was left to the Unit Managers. The DON acknowledged she had not been made aware of skin assessment concerns. When queried regarding R#804, the DON explained the resident had been seen by the wound care NP on 6/12/20 and it did not appear the resident was seen after that. Per the DON the resident's wound had a cap on it, the nurses were saying R#804's wound was an unstageable pressure ulcer, and when queried the DON acknowledged she agreed with this assessment. When queried as to how R#804 developed the pressure ulcer in the first place, the DON was unable to provide a response. R805 On 8/13/20 at 9:45 AM, R805 was observed lying on their back in bed. A low air loss mattress was observed to be on. When interviewed, R805 was difficult to understand. A review of R805's clinical record was conducted and revealed the following: R805 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A MDS assessment dated [DATE] documented R805 had severely impaired cognition, no behaviors including rejection of care, and

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) required extensive assistance for bed mobility, two person assistance for transfers, and was totally dependent on staff for toilet use. Resident data provided by the facility indicated that R805 had a facility acquired Stage III Pressure Ulcer. A review of what was explained to be the facility's weekly Wound Rounds typically conducted by a unit manager revealed one assessment dated [DATE] which documented a Stage III pressure ulcer to R805's right buttock. It was documented the pressure ulcer had been debrided (dead tissue removed) and had light serosanguineous drainage (serum and blood) and measured 3.5 cm x 4.5 cm x unknown depth. On 8/6/20 at 9:48 AM, a request for access to the Wound Rounds documentation was made to the Administrator. A review of R805's Skin Observations evaluations was conducted and revealed the following: A skin observation dated 3/12/20 documented, admitted with moisture associated redness on sacral area .Skin is currently intact . Pink scar tissue on coccyx . The next skin observation was documented two months later on 5/14/20 and documented, .coccyx .nickel size reddened area . Approximately one month after the 5/14/20 skin observation, a skin observation dated 6/10/20 documented, .excoriation to right and left buttock .tx (treatment) in place .On 7/1/20, a skin observation documented, .coccyx treatment in progress - no new areas of concern The subsequent skin observations were as follows: 7/16/20 .Sacrum .treatment in place 7/22/20 Left buttock, right buttock, groin. There was no description of what was observed at those areas. 7/29/20 Left buttock, right buttock with no description of the areas. 8/5/20 Right buttock, left buttock 8/12/20 Left buttock, right thigh (front) .tx in place A review of R805's progress notes revealed no documentation of the changes in R805's skin integrity between May 2020 and August 2020 besides a Daily Skilled Note dated 6/10/20 that documented R805 was receiving skilled services for wound care. On 8/13/20 at 11:50 AM, the DON and Administrator reported the Wound Rounds documentation could be accessed with a staff member and reported the documentation from the outside wound practitioner would be scanned into the electronic medical record. On 8/13/20 at 2:50 PM, Wound Rounds documentation, risk assessment documentation, and R805's clinical record was reviewed with the DON. The following was documented: On 3/18/20 (upon readmission into the facility), R805 was assessed to be at risk to develop pressure ulcers according to their Braden Score (a standardized assessment used to assess residents' risk of developing pressure ulcers). R805 was assessed to be at risk on 4/1/20 as well. There were no assessments of the moisture associated redness documented in the skin observation on R805's sacral area. The skin observation did not include any description or size of the reddened area. At that time, the DON was queried about interventions that were in place for R805's change in skin integrity to the sacrum. Physician orders [REDACTED]. It was documented that R805 was discharged to the hospital on [DATE] and readmitted into the facility on [DATE] at which time they were assessed to be at risk of pressure ulcer development. On 6/3/20, R805 was assessed to be at moderate risk for pressure ulcer development. The first Wound Assessment Details Report (Wound Rounds assessment) for R805's coccyx (sacrum) was dated 5/20/20 and documented facility acquired Moisture Associated Skin Damage (MASD) due to incontinence. The clinical stage was documented as Superficial and the area measured 0.60 cm x 2.10 cm x 0.10 cm with scant bloody exudate (drainage). The next Wound Assessment Details Report dated 5/27/20 documented MASD to R805's coccyx. The clinical stage documented, denuded (excoriated). The wound measurements were significantly larger than the last assessment at 6.5 cm x 6.0 cm x 0.10 cm with light bloody exudate. At that time, the current plan documented a comment on the form to indicate R805 was to receive a [MEDICATION NAME] dressing every three days. A review of physician's orders [REDACTED]. From 5/20/20 until 6/12/20, R805 received only a barrier cream to the peri-area. A Wound Assessment Details Report dated 6/4/20 documented MASD to R805's coccyx. The clinical stage documented denuded. The documented wound measurements were 6.5 cm x 6.0 cm x 0.10. The current plan and comments documented, wound is opening further. considering changing order to xeroform gauze with boarder <sic>gauzed dressing. will have wound care np (nurse practitioner) round on resident tomorrow. Physicians Orders did not document an order for [REDACTED].Yellow Base [MEDICATION NAME], minimal Yellow Slough (non-viable yellow, tan, gray, green or brown tissue) . At that time, a collagen and silver gel wound treatment was ordered. R805's care plans were reviewed at that time and revealed the following: A care plan initiated on 7/18/18 documented, The resident is at risk for skin impairment r/t (related to) limited mobility, episodes of incontinence, Dx (diagnosis) of IDDM (insulin dependent diabetes mellitus), needs extensive assist for transfers. All interventions were from 2016 and 2017, except one intervention initiated 3/12/20 that documented, Apply barrier cream to help protect skin from excess moisture every shift and after episodes of incontinence. A second care plan initiated on 7/18/18 documented R805 had an actual impairment to skin integrity on the coccyx due to pressure. Interventions were initiated on 7/24/18 and included evaluating and treating the area according to physicians orders and evaluating for signs and symptoms of infection. There were no care plans that addressed the current Stage III pressure ulcer to R805's coccyx or interventions implemented after the development of the wound. The DON was queried about how the nurses who conducted the skin observations would know if a resident's pressure ulcer worsened or changed. The DON reported they would review the wound assessment in Wound Rounds, get report from the previous shift, and talk with one another. When queried about how R805 went from MASD (from the facility's assessments) from 3/12/20 through 6/10/20 to a Stage III pressure ulcer (according to the wound NP) on 6/12/20, the DON did not offer a response. Review of a facility policy titled, Skin Management Guideline dated 11/28/17 documented, in part, Purpose: To ensure residents that are admitted to the facility are evaluated to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care B. Monitoring of Skin Integrity -Skin will be observed daily during cares by the nursing assistants. If any skin concerns are noted, they are to be reported to the licensed nurse. -Weekly skin observation on the bath/shower day will be performed by a Licensed Nurse. -If a skin concern is noted, refer to the skin and wound care formulary -The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. -The physician will be consulted with changes suggesting impairment in skin integrity .
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 Number: MI 895. Based on observation, interview, and record review, the facility failed to ensure the front door to the building was properly secured while there was no front desk staff on duty when one (R801) of three residents reviewed for accidents, was actively exit seeking, resulting in the resident exiting the building, running away from staff, and sustaining a fall which resulted in a hospital transfer and an abrasion, bleeding, and bruising to the face. Findings include: Multiple complaints were submitted to the State Agency that alleged R801 exited the facility and had a fall. On 8/12/20 and 8/13/20, an unannounced onsite investigation was conducted at the facility. On 8/12/20 at 10:50 AM, R801 was observed seated in the dining room playing cards with another resident. R801's left forehead, eye, and under the eye was observed to have multi-colored discoloration. R801's room was observed to be at the far end of the Oxford unit. In order to get from the Oxford unit to the front lobby, it was necessary to navigate the hallway of the Oxford unit, walk past the nursing station, turn right, and walk down the hallway of the Oakland Unit. On 8/12/20 at 11:50 AM an observation was made of the nursing station located between the Oakland and Auburn unit. To the right of the nursing station, a wooden half door separated the resident area from the front lobby. When opened, the half door alarmed unless a code was punched into a keypad. A desk where Receptionist K was seated, was located in the lobby between the half door and the doors to exit the facility. To exit the facility from the lobby, there were two glass doors which led to a sidewalk. The sidewalk led to a parking lot. The facility was located on a main road with accessible sidewalks. On 8/12/20 at 12:15 PM, an investigation conducted by the facility was reviewed and revealed the following: An Investigation Summary for R801 documented, .On 8/8/20, Resident (R801) had been stating that he wanted to leave earlier in shift but had been redirectable until this point. Resident wanted to leave r/t (related to) wanting glue for his slipper. At approximately 1pm resident (R801) exited the facility via the front door witnessed by housekeeping who yelled to the nursing staff 'that man just went out the door' all door alarms were sounding appropriately . .The nursing supervisor and CNA (Certified Nursing Assistant) left facility with the resident who walking thru <sic> the parking lot towards the road. The resident started walking down the sidewalk with the staff, and became combative with the staff swinging at them, next resident started running towards the street. Staff was able to intervene before resident reached the street, resident then attempted to change directions and tripped. Resident fell to ground before staff could prevent fall, resident struck head on sidewalk. Nursing immediately assessed resident for injuries, noting abrasion to left eye .911 had been initiated when resident first exited facility, and they then arrived. MD (Medical Doctor) was notified .ordered to send resident with 911 to hospital for evaluation r/t head

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) abrasion . A signed statement from an interview conducted by Nurse Supervisor, Nurse L with Nurse A on 8/8/20 documented, Patient was observed walking towards Auburn Hall. patient was redirected and asked why he was trying to leave. He stated he was looking for glue. I told him that he could receive glue from maintenance staff. Patient responded by brushing pass me and opening up the alarmed door half way and proceeded to the main entrance into the parking lot, down to the sidewalk on (street name redacted), where he was escorted by several nurse and staff accompanied patient while 911 was called for assistance. Patient became combative and struck out at several staff members while attempting to run away while he fell face first forward . A written and signed statement by Nurse L dated 8/8/20 documented, Resident was observed seeking exit throughout morning stating, Which way do I get out? Resident continued to wander about facility. At time of incident, the resident was near Auburn nursing station looking for an exit. Staff intervened to redirect resident to no available <sic>. Resident ran pass staff to get out of half door and advance through front entrance/exit. Staff attempted to redirect once the resident made it to the parking lot but resident was persistent and advanced to sidewalk. Writer and other staff walked at either side of resident when he began to swing at staff, then run down sidewalk subsequently ending in a fall .resident transferred to (hospital name redacted) for ob (observation) due to head trauma caused by fall . A signed statement from an interview conducted by Nurse L with CNA J dated 8/8/20 documented, At about 12:45 PM, the housekeeper yelled out, 'The man is out of the building.' I then proceeded out of the door, through parking lot to the sidewalk to assist. I kept trying to redirect resident but he was agitated and said, 'I'm going to get glue from the store.' He wouldn't come back and that is when he proceeded to become combative and run where he then fell and hit his face after trying to run . On 8/12/20 at 2:20 PM, Housekeeper I was interviewed. When queried about what occurred with R801 on 8/8/20, Housekeeper I reported R801 kept asking for glue and made statements about leaving the building. Housekeeper I reported the nurse on duty attempted to redirect the resident but the resident just took off and exited through the half door and through the glass doors that led to the outside of the facility. When queried about whether or not the glass doors were locked, Housekeeper I stated, They are usually locked, but they were not locked at the time. On 8/12/20 at 2:40 PM, video footage from the Auburn hallway, the front lobby, and the Auburn/Oakland nursing station from 8/8/20 was reviewed in the presence of the Maintenance Director and the Administrator. The time of the event was between approximately 12:35 and 12:45 PM. In the videos, Nurse A is observed entering the facility from a lunch break at approximately 12:35 PM. R801 entered the Oakland unit at approximately the same time. A view of the hallway that lead to the Auburn unit, showed R801 pacing down the hallway which also had closed double doors to a service hallway. Several staff members are observed in that hallway, including a nurse at a medication cart identified as Nurse N, Housekeeper I, and Nurse A. Nurse A is observed to be standing at the end of the hallway holding a cup. R801 walked toward Nurse A, squeezed to the side of them, and opened the half door. R801 then opened both glass doors without any effort and exited the building. Approximately 8-10 minutes later, R801 re-entered the facility with the assistance of staff and was bleeding from the face. The camera view of the outside of the building was reviewed. R801 walked through the parking lot with staff following, approached the sidewalk, and began walking fast down the road with staff behind him. On 8/12/20 at 3:00 PM, Nurse A was interviewed. When queried about the incident with R801 on 8/8/20, Nurse A reported R801 was a known wanderer. Nurse A reported R801 always wandered around the facility but did not typically make statements about wanting to leave. Nurse A further reported R801 came down to the Oakland Unit and was asking for glue for their slipper, paced down toward the Auburn Unit, tried to enter the Service Hall doors, then walked back toward the nursing station. Nurse A reported they were standing near the wooden half door and R801 walked toward them and walked around them and exited the half door, and then through the glass doors to the outside of the building. R801 was followed by multiple staff members, but was not redirectable. Nurse A further reported R801 became combative with the staff outside and began to run which resulted in R801 falling. Nurse A assisted R801 back into the facility and cleaned their face from blood and then EMS came and took over. On 8/12/20 at 3:30 PM, Receptionist K was interviewed. Receptionist K reported they worked Monday through Friday until 5:00 PM. Receptionist K sat in the front lobby and when they were seated there, they did not keep the glass door locked. Receptionist K reported when they left at 5:00 PM, the magnetic door was engaged and required a button to be pressed in order to open the door. Receptionist K reported the facility did not have a receptionist who worked in the evenings or on the weekends. On 8/12/20 at 3:50 PM, the Maintenance Director was interviewed. When queried about the glass door at the entrance of the building, the Maintenance Director reported the door remained unlocked when Receptionist K was working and Receptionist K locked the doors when they left at the end of their shift. The Maintenance Director reported they checked the door a second time before they left. The Maintenance Director reported when the inner most glass door was locked, a magnetic lock engaged which then would require either a keypad code or a button pressed from the inside to disengage the magnetic lock and open the door. The Maintenance Director reported that someone could exit the door in an emergency if they pressed on it for 15 seconds or if they exerted 150 pounds of pressure toward the door. When queried about the video of R801 walking through the door effortlessly on 8/8/20, the Maintenance Director reported it did not appear to be locked. At that time, an observation of the magnetic door when locked was conducted with the Maintenance Director. When locked, the door would not open even with a bit of force. The Maintenance Director reported the door could not have been locked based on the video of R801. When queried about how the door would have been unlocked, the Maintenance Director reported an extra key was kept in the medication cart and the nurse had access to it. On 8/12/20 at 3:59 PM, an interview was conducted with Nurse L via the telephone. Nurse L was queried about the events that occurred on 8/8/20 with R801. When queried about the front door, Nurse L reported it was typically locked on the weekends and the only way it would get unlocked was if one of the staff members unlocked it with the keys kept in the medication cart. On 8/13/20 at 8:30 AM, CNA F was interviewed. CNA F explained that R801 had been wandering to the Oakland/Auburn nursing station all morning on 8/8/20 and a housekeeping staff took them back to their room. CNA F reported after R801 was taken to their room, they came right back up to the front of the facility. CNA F reported R801 was agitated all morning and eventually exited out of the facility through the front lobby. CNA F stated, A nurse and CNA ran after him. If it wasn't for that, he would have been hit by a car. On 8/13/20 at 8:45 AM, the Director of Nursing (DON) was interviewed. When queried about the investigation into the incident with R801 on 8/8/20, the DON reported they were not working that day, but staff contacted them and Nurse L conducted the investigation. The DON reported R801 did not have a history of exit seeking but did wander the facility. On 8/8/20, the DON reported R801 did not try to exit the building until they wandered to the Oakland/Auburn nursing station. On 8/13/20 at 9:10 AM, the Administrator was interviewed. When queried about R801 on 8/8/20 and how the facility could have prevented them exiting the building and subsequently falling, the Administrator stated, Door security and better supervision. The Administrator reported they did not know why the front door was unlocked and it should have been when there was no receptionist there. R801's clinical record was reviewed and revealed R801 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated 6.26.20 documented R801 had moderately impaired cognition and no behaviors, including wandering and was independent with supervision with ambulation. A facility policy titled, Wandering and Elopement Guidelines was reviewed and documented, .At any time during a resident stay there may present indication of an elopement risk. Example: Making statements of wanting to leave, attempting to actively exit or wear coat making statements of have an appointment etc. It is the responsibility of our staff to remain with the resident until a licensed nurse is able to conduct an evaluation .
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** This citation pertains to MI 8 and MI 1: Based on interview and record review the facility failed to ensure a physician-prescribed inhaler was present at the facility to administer per order for one (R#803) of three residents reviewed for medications, resulting in voiced complaints regarding the medication not being available. Findings include: On 8/12/20 at approximately 2:40PM, R#803 was queried in regard to their inhalers, and explained the facility would wait until the last second to order the resident's inhaler. Review of the clinical record for R#803 revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's quarterly minimum data set assessment dated [DATE] the resident scored 15 out of 15 on a brief interview for mental status exam, which indicated the resident was cognitively intact. Review of physician orders [REDACTED]. Review of the resident's Medication Administration Record [REDACTED]. Review of progress notes for R#803 revealed the following: A note dated 8/10/20 at 8:13PM documented the medication was not available, and a note dated 8/11/20 at 10:37AM also documented the medication was not available, and documented the pharmacy was notified. On 8/13/20 at 8:45AM the facility's Director of

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Nursing (DON) was queried regarding medication reordering, and explained when the medication became low she believed staff would reorder it. The DON explained she would need to double check the process. When queried about how long it took to obtain if the pharmacy was contacted, the DON explained it was usually within 24 hours to deliver unless there was an issue. A facility policy related to medication administration and ordering was requested from the facility, and was not provided by the end of the survey.