| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235547 | A. BUILDING _____ B. WING _____ | 07/07/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C | 37700 HARPER AVENUE CLINTON TOWNSHIP, MI 48036 |

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 0677<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to Intake numbers MI 654, 3, and 1. Based on observation, interview, and record review the facility failed to provide sufficient Activity of Daily Living (ADL) care staffing to meet the medical, physical, and psychosocial needs of the residents affecting five residents (R501, 502, 503, 504, and 506) of six residents reviewed for ADL care with the likelihood of a lack of timely incontinence care and overall resident verbalization of dissatisfaction with care. Findings include: R 504 On 07/07/20 at 11:09 AM, R504 was interviewed regarding the care received at the facility and stated, I've been waiting since breakfast to have my bed changed. The bed was observed to be wet with urine from the top of the bed down to the knee area and from side to side. A dark ring had developed around the wet area where drying had started and two flies were on R504's pillow. R504 then stated, I asked them to change the bed this morning. I asked to take a shower too. I had a shower several days ago but I need one now. I had to change my own brief, this happens a lot. I wanted to go to (another nursing home) but they put me here. Record Review of R504's EHR revealed R504 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated , 03/19/20 revealed R504 had a BIMS score of 15 of 15 and needed supervision with ADLs including Hygiene and toileting. Further review revealed on the task view form for hygiene that no hygiene (bath/shower) were documented on June 9th, 12th, 13th, 14th, 15th,16th,17th,18th, 27th, or 28th. Nor was any hygiene documented on July 1st, 2nd, 3rd, or 5th. On 07/07/20 at 11:16 AM, an interview was conducted with Nurse H regarding R504's requests and stated, They changed him at 7:00 AM, and this happens a lot. We don't have enough CNA help. In fact sometimes the nurses have to work as CNAs. R506 On 07/07/20 at 12:16 PM, R506 was interviewed regarding call light response time at the facility and stated, The waits always at least 20 minutes or more. In fact one day at 5:30 in the morning I turned the light on and no one came in until after nine. I have a sore on my back and the dressing leaks and I have to lay in a wet bed. Record review of R506's EHR revealed R506 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED].) The most recent MDS dated , 03/26/20 revealed R506 had a Brief Interview for Mental Status BIMS score of 15 of 15 indicating an intact cognition and needed extensive assistance with ADLs including dressing and hygiene. R501 On 07/02/20 2:00 PM, R501's confidential complainant's allegations were reviewed and revealed, The resident was left wet for extended periods of time, the resident was left in a gown with a bad odor, and the staff are not showering the resident. Record review of R501's Electronic Health Record (EHR) revealed R501 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment date 04/29/20 revealed R501 had a severely impaired cognition and needed extensive assistance with Activities of Daily Living including dressing, hygiene, and toileting. Further review revealed on the task view form for hygiene that no showers were documented in June. R502 On 07/02/20 at 2:10 PM R502's confidential complainant's allegations were reviewed and revealed, The resident was left soiled for extended periods of time, and call lights are not answered in a timely manner. Record Review of R502's EHR revealed R502 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS assessment revealed R502 had a Brief Interview for Mental Status (BIMS) score of six indicating a severely impaired cognition and needed extensive assistance with ADLs including hygiene and toileting. Review of R502's POC (plan of Care) Resident Response Rate Report, Task: Bath/Shower/BedBath. R502 received five showers and 20 bed baths from 3/1/2020 to 3/31/2020. R503 On 07/07/20 at 11:00 AM, R 503's confidential complainant's allegations were reviewed and revealed, The facility staff failed to adequately groom the resident. Record Review of R503's EHR revealed R503 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] revealed R503 had a severely impaired cognition and was independent with ADLs including dressing and hygiene. On 07/07/20 at 10:20 AM, an interview was conducted with Nurse C regarding facility staffing assignments and stated, Staffing isn't that bad for the nurses, but for the aides, not that good. Usually we're supposed to run with four aides but usually we only have three, and about twice a week we have to run with two. On 07/07/20 at 10:41 AM, an interview was conducted with Certified Nurses Aide (CNA D) regarding staffing assignments and stated, Staffing has been terrible. We normally work with three CNAs over here. I've never been here with just two, but heard it happens. I've been on B-wing by myself and that unit has 26 residents. On 07/07/20 at 10:49 AM, an interview was conducted with CNA E regarding staffing assignments and stated Staffing here is like anywhere else. Sometimes we have to postpone a shower. On 07/07/20 at 11:03 AM an interview was conducted with CNAs F and G regarding staffing assignments and stated, Staffing is terrible. We are taking care of 29 residents. This happens every day. CNA F stated, We do get so far behind that we can't get to all of the showers. On 07/07/20 at 3:00 PM the Director of Nursing (DON) was asked about the facility's policy and procedure regarding call light response time and the resident's complaints of waiting for long periods of time for assistance with ADLs and stated, When we get complaints of long waits we can pull the call light logs, depending on where in the building and check on the wait times. Review of the facility's policy and procedure titled, ACTIVITIES OF DAILY LIVING (ADL) (DAILY LIFE FUNCTION) with an Origination Date: July 1,2008 revealed, 2. To provide assistance to the resident as needed. |
| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This Citation pertains to Intake numbers MI 763 and 1. Based on observation, interview, and record review the facility failed to turn and reposition dependent residents affecting two residents (R505 and R506) of four residents reviewed for pressure ulcers with the likelihood of the worsening of existing pressure ulcers or the development of new pressure ulcers. Findings include: R505 On 07/07/20 at 9:06 AM, R505 was observed sleeping in bed facing the right side of the bed. R505 did not respond to knocking on the door or a greeting. On 07/07/2020 at 10:34 AM, R505 was observed sleeping and facing the right side of the bed. On 07/07/20 at 12:55 PM, a wound observation was conducted with Nurse A. R505 was observed sleeping in bed facing the right side of the bed. Nurse A attempted to awaken R505 and inform the resident of the procedure. Nurse A then partially removed the dressing from R505's left hip to reveal an irregularly shaped wound with a dark reddish brown center surrounded by pink tissue and covered with a medicated wound care cream. Nurse A then redressed the wound and was asked about the turning and repositioning of R505 and stated, They turn (R505) from the right side to (R505's) back to keep the pressure off the left hip. Nurse A was then asked to check the condition of R505's right hip and stated, (R505) only has the one pressure ulcer. Then turned R505 to face the left side of the bed. An irregularly shaped reddish brown area over the bony prominence of the right hip about 2 inches across was observed. Nurse A stated, That's new, that wasn't there, I'll get orders now. On 07/07/20 at 3:00 PM, an interview was conducted with Certified Nurses Aide (CNA B) regarding the facility's policy and procedure on turning and repositioning residents and stated, I turned (R505) twice. One time in the morning and again at 1:00 PM. Record Review of R505's Electronic Health Record (EHR) revealed R505 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated , 04/29/20 |

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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| **LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C** | **37700 HARPER AVENUE CLINTON TOWNSHIP, MI 48036** |

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| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>revealed R505 had a severely impaired cognition and needed extensive assistance with Activities of Daily Living (ADLs) including bed mobility. Further record review revealed R505's left hip pressure ulcer measured 1.66 cm (centimeters) by 1.4 cm on 06/29/20 and 2.16 cm by 2.01 cm on 07/06/20. R505's care plan intervention for skin integrity included, Encourage me to make small, frequent shifts in my position and Please help me get turned and repositioned while in bed or in my wheelchair. The care plan did not include a time interval for the interventions. R506 On 07/07/20 at 9:35 AM, R506 was observed sleeping flat on their back in bed and did not respond to knocking on the door or greetings. On 07/07/20 at 12:16 PM, R506 is awake and eating lunch with the head of the bed elevated. R506 was asked about having a pressure ulcer and stated, I have a sore on my back and they change the dressing every day but one day it's done real early in the morning and the next day it might not be changed until after 10:00 at night. They rarely help me turn on my sides, I can pull myself over but I can't stay there. When I do get someone to help me they put a pillow behind me and I get relief on my sore. In fact I've laid in one position for up to 24 hours. Record review of R506's EHR revealed R506 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED].) The most recent MDS dated , 03/26/20 revealed R506 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition and needed extensive assistance with ADLs including bed mobility. On 07/07/20 at 12:55 PM, Nurse A was asked about the turning and repositioning of the residents and stated, (R506) doesn't like to turn. On 07/07/20 at 3:00 PM, the Director of Nursing (DON) was asked about the facilities policy and procedure on turning and repositioning residents and stated, It should be every two hours. Review of the facility's policy and procedure titled, WOUND MANAGEMENT PROGRAM with a Revised Date: 8/17/2017 revealed 3.1 Verify that resident- specific Care Plan interventions are in place (pressure relieving devices, turning schedules, etc.). |