STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235545	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENCY AT WHITMORE LAKE	8633 N MAIN ST WHITMORE LAKE, MI 48189

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to intakes #'s: MI 598 and MI 220. Based on interview and record review, the facility 1) Failed to follow their policy and procedure for medication administration and investigate a medication error for one sampled resident (R1) out of one resident reviewed for medication administration, and 2) Failed to effectively provide an environment to address patient care needs for up to 114 additional facility residents, resulting in the likelihood that residents would experience anger and distrust towards facility staff, the potential for patient care needs and issues with pain to be delayed and/or unmet. Findings include: Resident #1 (R1) was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. On 8/4/20, a record review of R1's electronic medical record (EMR), dated 7/6/20, revealed R1 had a Brief Interview for Mental Status score of 15 out of a possible 15 points which indicated R1 had no difficulty with her ability to think. In addition, R1's Minimum Data Set (MDS) which was done on 7/6/20 indicated R1 was a two person assist and totally dependent on facility staff for all activities of daily living (ADLs). On 8/4/20 at 12:05 PM, R1 was interviewed. R1 stated, on 7/27/20, she was to receive multiple medications before bedtime between 7 to 9 PM. R1 stated she did not receive her medications as scheduled. At 12:30 AM (past midnight) on 7/28/20, an agency nurse (AN) I woke her to administer her the 8:00 PM medications. AN I was asked to identify the medications and she was unable to do so, according to R1. R1 stated she complained to Director of Nursing (DON) B who responded to her complaint by saying Haven't you ever made a mistake? R1 said she responded she (R1) had never made a mistake that involved other people's lives. R1 said she was frustrated with the facility management because they never fix any of her concerns but sweep them under the rug. On 7/5/20, a record review of the complaint form completed by R1 was reviewed. The facility response to R1's concern regarding receiving medications late was speak to staff on resident med pass times and resident care. The response to what action to be taken was re-educated staff on importance of med pass times and resident care. The form was signed by DON B and co-signed by Administrator A. On 7/5/20 at 8:25 AM, Assistant DON (ADON) C was interviewed. ADON C described R1 as difficult but said "we do our best to care for her. ADON C stated she did an investigation into the allegation that R1's medications were provided to R1 outside of the normal range of time for providing medications at HS (hour of sleep). On 7/5/20, a record review of the investigation of the med pass error was done. According to the information in the document, the nurse assigned to care for R1 was not able to give R1 her medications as ordered by the physician due to numerous interruptions (other residents required care, doctor's orders needed clarifying, etc) so AN I was asked to assist with medication pass. When AN I attempted to give R1 her medications, R1 became irate and was yelling at AN I. According to the investigation, R1 declined her medications. Both nurses were educated via phone about administering medications timely, notifying the resident's physician when medications were late and to seek assistance from their peers as needed in a timely fashion. The actions taken included the educations of the nurses caring for R1, the decision to not assign AN I to care for R1 and a reminder notice in the medication cart alerting staff nurses to give R1 her evening medications promptly. There was no evidence that ADON C spoke with other residents on that unit about receiving evening medications later than scheduled. On 7/5/20, a record review of the medication administration audit report, dated 7/28/20 at 9:42 ET (eastern time), was received and reviewed. According to the report, R1 was scheduled to receive the following medications at 8:00 PM (range of time from 7:00 PM to 9:00 PM) on 7/27/20: -Trazadone HCL 150 milligram (mg) table - 75 mg (half a tablet) for depression and [MEDICAL CONDITION] -[MEDICATION NAME] Capsule 500 mg orally three times a day every Monday, Wednesday and Friday for [MEDICAL CONDITION] (high platelet count in the blood) -Duloxetine HCL Delayed Release Particles 30 mg, 1 capsule by mouth at bedtime related to major [MEDICAL CONDITION] -Atorvastatin Calcium tablet 10 mg, give one tablet a day for hyperlipedemia (elevated lipids in the blood) According to the report, Trazadone HCL was given to R1 on 7/28/20 at 1:04 AM, [MEDICATION NAME] was given to R1 on 7/28/20 at 1:01 AM, Duloxetine HCL was given to R1 on 7/28/20 at 12:13 AM and Atorvastatin Calcium was given to R1 on 7/28/20 at 12:59 AM. On 7/5/20, a record review of the Medication Administration Policy and Procedure, release date: 03/2013, stated Administer medications within 60 minutes of the scheduled time. During the survey process from 8/4/20 to 8/7/20, multiple nursing and facility staff were interviewed onsite in person and by phone. Below are the following statements from staff who desired to remain anonymous for fear of retaliation: Anonymous Staff (AS N) revealed that when nursing staff was low, I don't think its very safe at all. During periods of short staffing AS O revealed residents would complain of needing assistance, it was not an ideal situation, made them (ASP) feel bad, and that It is not possible the resident is going to get the care that they need. AS Q revealed that residents were only able to receive a fair amount of patient care when nursing staff was short. When staffing was short lots of residents would complain of their medications being late, per AS P. Residents would be in pain, and had to wait for nursing staff to return to administer their pain medication, when working on multiple units. Nursing staff also complained of working short, which made it very hard on staff, causing them to feel very stressed while trying to care for the facility residents. Several random staff revealed there would be times, when only 1 nurse and 1 Certified Nursing Assistant (CNA) were working on a hall. When the nurse would leave the given unit to go the other unit (they had to work on), it would be left up to the CNA to care for no less than 20 residents by themselves consisting of fall risk residents. It was revealed that those residents needing 1:1 observation/patient care were not able to receive it.

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