STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235352	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASS COUNTY MEDICAL CARE FACIL	23770 HOSPITAL ST CASSOPOLIS, MI 49031

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 0582 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) detailing estimated charges for continued services in 2 of 3 residents (Resident #27 & #36) reviewed for timely provision of notifications, resulting in the potential for residents/resident representatives to be unaware of changes in regard to financial liability. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) information related to Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms, page last updated 9/19/19, revealed .Skilled Nursing Facilities (SNFs) must issue a notice to Original Medicare (fee for service - FFS) beneficiaries in order to transfer potential financial liability before the SNF provides .an item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or .custodial care .For Part A items and services: SNFs use the SNF ABN as the liability notice . Obtained from: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN- Review of the policy/procedure Distribution of Notice of Medicare Non-Coverage (NOMNC) notice and Advanced Beneficiary Notice (ABN), dated 10/2020, revealed .It is the policy of (Facility Name) to provide timely notices when a service or item that is usually paid for by Medicare is no longer medically reasonable or necessary or for custodial care. The facility shall inform Medicare beneficiaries/representatives of his or her potential liability for payment .To ensure that the Medicare beneficiary/representative has enough time to decide whether to appeal end of coverage decision (Medicare Part A) or receive the services in question and assume financial responsibility (Medicare part B), the Social Worker or designee will deliver and explain the notice within 48 hours of non-coverage .ABN letter informs beneficiary of potential costs to them after coverage ends . Resident #27 Review of an Admission Record revealed Resident #27 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Noted Resident #27's daughter was her POA (Power of Attorney) and responsible party. Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 8/12/20, revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated severe cognitive impairment. Review of the census information revealed Resident #27 had a primary payer change to Medicare Part A on 7/19/20, which indicated Medicare Part A paid for services provided to the resident beginning on that date. Further review of the census information revealed Resident #27's primary payer changed to Medicaid on 8/11/20, indicating that as of that date, Medicare Part A no longer paid for services provided. Review of the SNF Beneficiary Protection Notification Review form for Resident #27, completed by facility staff, revealed .Last covered day of Part A Service .8/10/2020 .the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted . Under the section .Was an SNF ABN, Form CMS- provided to the resident? the box was checked No, with the explanation .Was not warranted (at) this time . Resident #36 Review of an Admission Record revealed Resident #36 was a [AGE] year-old female, readmitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Noted Resident #36's sister was her POA (Power of Attorney) and responsible party. Review of a Minimum Data Set (MDS) assessment, with a reference date of 8/31/20, revealed Resident #36 had severe cognitive impairment. Review of the census information revealed Resident #36 readmitted to the facility on [DATE] with Medicare Part A as her primary payer, which indicated Medicare Part A paid for services provided to the resident beginning on that date. Further review of the census information revealed Resident #36's primary payer changed to Medicaid on 8/28/20, indicating that as of that date, Medicare Part A no longer paid for services provided. Review of the SNF Beneficiary Protection Notification Review form for Resident #36, completed by facility staff, revealed .Last covered day of Part A Service .8/27/2020 .the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted . Under the section .Was an SNF ABN, Form CMS- provided to the resident? no box was checked, with the explanation .Was not warranted at this time . handwritten under the instructions for the No response. In an interview on 10/6/20 at 11:44 a.m., Social Services Director G reported she and MDS Coordinator F work together to determine coverage dates and provide NOMNC and SNF ABN forms to residents as required. Social Services Director G reported NOMNC forms are provided to residents discharging from Medicare Part A, and SNF ABN forms are only provided to residents discharging from Medicare Part B. In an interview on 10/6/20 at 11:53 a.m., MDS Coordinator F reported she notifies Social Services Director G of upcoming resident discharge date s from Medicare Part A services, and Social Services Director G then prepares the required forms and performs the necessary notifications/obtains signatures. MDS Coordinator F reported the SNF ABN forms are only used for residents discharging from Medicare Part B services, and stated the SNF ABN form .contains information about how if they want to keep receiving services the cost to them .whatever skilled services they are getting . MDS Coordinator F reported no SNF ABN forms were provided to Resident #27 or Resident #36 because those residents were receiving services covered by Medicare Part A. In an interview on 10/6/20 at 2:15 p.m., Social Services Director G reported the facility was instructed by a consultant to only provide SNF ABN forms to residents discharging from Medicare Part B services, and stated .we were under the impression that the NOMNC takes care of Part A .
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to utilize and maintain complete lost/missing item documentation for 1 of 13 residents (Resident #2) reviewed for resolution of grievances, resulting in the potential for residents to not meet their highest practicable level of wellbeing due to grievances not being documented, tracked, and the results of conclusions and/or resolutions not being recorded. Findings include: Review of a facility policy Lost/found; safeguarding personal belongings last revised 10/1/20 revealed, .Lost Items 1. If an article of residence clothing or other resident belonging is reported missing, the charge nurse or unit manager will be notified immediately. And immediate search will include notification of dietary, laundry, housekeeping and other nursing units. If the item is not found within one hour, the charge nurse or unit manager will complete a lost/found item report, which will be submitted to the director of social services. 2. An extensive search will be conducted for the missing items. Any items not found within two hours, will be reported to the administrator. The administrator will make the determination regarding the next step .3. Final resolution of the missing item will be noted on the lost/found item report sheet. The completed report will be filed in the office of the director of social services in a designated binder. Review of a Minimum Data Set (MDS) assessment for Resident #2, with a reference date of 9/23/20 revealed Resident #2 was a [AGE] year-old male originally admitted to the facility on [DATE],

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) with pertinent [DIAGNOSES REDACTED].#2 was cognitively intact. During an interview on 10/01/20 at 11:46 A.M., Resident #2 reported that he had been waiting for the facility to find his shorts for approximately 2 months. Resident #2 stated, .the last I heard is that they would have to check the other halls .I would be happy just getting a new pair of shorts . During an interview on 10/06/20 at 12:44 P.M., Social Worker (SW) G reported that she was not aware of any missing items for Resident #2 and that when a resident is missing a clothing item, it is handed off to Housekeeping Director (HD) J to handle. During an interview on 10/06/20 at 12:58 P.M., regarding missing clothing for Residents #2, HD J reported that she was made aware late yesterday that he was missing a shirt and stated, .yes, I knew he was missing a pair of shorts too .we are keeping an eye out .I do not have a missing item paper .that should be at the nurses station in a binder . Review of the Lost/Found binder did not include any forms for Resident #2. During an interview on 10/6/20 at 1:05 P.M., Laundry Aide (LA) P reported that Resident #2 had first reported his shorts missing approximately a week ago and then mentioned it again yesterday. LA P stated, .I told him that I would look again .I reported it to SW G and she is taking it from here .I don't know what they do .I don't fill out any forms . Review of Lost/Found Item Reports requested for Resident #2, provided on 10/2/20 at 12:28 P.M. by Medical Records Director Q, did not reveal any reports for Resident #2. During a second interview on 10/06/20 at 02:51 P.M., SW G reported that she did not have documentation that Resident #2 was missing any items and stated, .this process is a work in progress .
F 0657 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: MI 581 Based on observation, interview, and record review, the facility failed to review and revise a comprehensive, individualized plan of care for 3 of 13 residents (Resident #8, #46, and #45) reviewed for care plans, resulting in Resident #8's fall with fractures and the potential for impaired physical, mental, and psychosocial well-being. Findings include: Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, If the patient's status has changed and the nursing [DIAGNOSES REDACTED]. An out of date or incorrect care plan compromises the quality of nursing care. Review and modification enable you to provide timely nursing interventions to best meet the patient's needs .It is necessary to revises related factors and the patient's goals, outcomes, and priories. Date any revisions. Revise specific interventions that correspond to the new nursing [DIAGNOSES REDACTED]. Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 257-258 Review of the facility policy Care Planning last revised 9/17 revealed, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .2. Comprehensive Care Plans .c. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. d. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. E. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: i. The attending physician. ii. A registered nurse with responsibility for the resident. iii. A nurse aide with responsibility for the resident. iv. A member of the food and nutrition services staff. V. The resident and/or the resident's representative, to the extent practicable. Most include an explanation in the medical record .f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. g. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive assessment (Admission, Annual or Significant Change) per current RAI guidelines. H. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. i. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions. Resident #8 Review of a Face Sheet revealed Resident #8 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 7/8/20 revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #8 was moderately cognitively impaired. Review of the Functional Status revealed that Resident #8 was independent with bed mobility and locomotion on unit and required supervision with no setup or physical help from staff for transferring or toileting. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 8/12/20 revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #8 was moderately cognitively impaired. Review of the Functional Status revealed that Resident #8 required supervision with one person physical assist for bed mobility, transferring, walking in room, and toileting. (Indicating Resident #8 had a decrease in her functional status from 7/8/20 to 8/12/20.) Review of Resident #8's Morse Fall Scale dated 7/6/20 revealed a score of 15 indicating Resident #8 was a Low Risk for Falling. Review of Resident #8's Care Plan revealed, AMBULATION: I am able to ambulate independently in room with 4WW (4 wheeled walker) Date Initiated: 02/14/2019 Resolved Date: 09/21/2020. Review of Resident #8's Therapy Screen dated 6/15/20 revealed, 3. Current transfer assessment .Independent. MOBILITY 1. Mode of locomotion a. Self ambulatory .Ambulation support a. Independent. Review of Resident #8's Therapy Screen dated 9/3/20 revealed, 3. Current transfer assessment .Stand by Assistance (SBA). MOBILITY 1. Mode of locomotion a. Self ambulatory .Ambulation support b. Stand by Assistance (SBA). Review of Resident #8's Physical Therapy Evaluation & Plan of Treatment: dated 8/10/20 revealed, .Assessment Summary-Clinical Impressions: Pt (patient) is an [AGE] year old long-term resident of this facility with a recent dx (diagnosis) of Covid-19 resulting in some increased difficulty with mobility requiring PT (Physical Therapy) to address .Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: further decline in function and falls. Review of Resident #8's Occupational Therapy Evaluation & Plan of Treatment dated 8/7/20 revealed, .Assessment Summary-Clinical Impressions: Client exhibits a decline due to [DIAGNOSES REDACTED].Risk Factors: Due to the documented physical impairments and associated functional deficits the patient is at risk for: falls and anxiety. During an interview on 10/06/2020 at 12:56 P.M., Physical Therapy Assistant (PTA) EE reported that at the time of Resident #8's last assessment in September she was a Stand By Assist for transferring and ambulation. PTA EE reported a Stand By Assist requires staff to be present during transferring and/or ambulation but does not require touching the resident. PTA EE reported that the Occupational Therapist documented that Resident #8 was independent in the bathroom and could do her own pericare but would need supervision to and from the bathroom. PTA EE reported that when there is a change in the residents needs it is reported to the unit managers and the unit managers update the care plans. Review of Resident #8's Incident Note dated 9/12/2020 at 20:33 (8:33 P.M.) revealed, This writer was passing med at the end of the hall while the blue light (emergency light) went off, running to the room and found res (resident) lying on her right at the rest room door, a pool of blood on the floor. Nose bleeding noted, bruise to left shoulder, skin tear to right elbow. Res is very confused, no answering question properly . Review of Resident #8's Incident Note dated 9/15/2020 at 14:51 (2:51 PM) revealed, IDT (interdisciplinary team) met and reviewed documentation. The team discussed how to proceed with plan of care and appropriate interventions. Staff reports that she (Certified Nursing Assistant 'CNA') was providing care to (Resident #8's) roommate (CNA) could hear that (Resident #8) was in the bathroom per her normal routine and then heard a scream then a smack. Staff member states she turned on the emergency light and the nurse entered the room. Nurse interview indicates upon post fall assessment, (Resident #8's) pajama bottoms halfway down her left buttocks on one side placing her at risk for falling. Nurse voiced (Resident #8) had been at baseline throughout her shift prior to this occurrence. It appears (Resident #8) tripped/slipped on low hung pants causing her to lose balance and come in contact with bathroom appliances and floor. Safety interventions in place. Nursing staff will reassess safety precautions upon readmission to this facility. Care plan reviewed. IDT will meet as needed. Review of Resident #8's Incident Report dated 9/12/20 at 8:14 P.M. revealed, At 1315 (1:15 P.M.), this writer was passing med at the end of the hall while the blue light went off, running into the room and found res lying on her right side at the rest room door, head toward room door, pajama pants half down buttocks on left side/pulled up on right, oxygen tubing in place but slightly under nostrils, blood on the floor from her face. Nose bleeding noted, bruise to left shoulder, skin tear to right elbow. Res is very confused status [REDACTED].

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F 0657 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Full set of VS (Vital Signs) taken, kept res comfortable but not moving and wait until the ambulance come. Daughter (name omitted) and son (name omitted) notified. NM (Nurse manager) (Name omitted) and on call MD Dr. (name omitted) notified. (Resident #8) did not present with any urinary frequency or confusion during shift and was functioning at baseline. Safety measures in place per care plan .Predisposing Physiological Factors (Confused), (Current UTI), (Recent change in Medication/New), (Recent change in Cognition), (Recent Illness), and (Weakness/Fainted) .Predisposing Situation Factors (Ambulating without Assist), (Recent Room Change), (Using Walker), and (Using Wheeled Walker). Review of Resident #8's Hospital Record dated 9/12/20 revealed, (CT Scan Result) Blowout [MEDICAL CONDITION] inferior orbital wall (eye socket) .Possible nondisplaced [MEDICAL CONDITION] wall of the right maxillary sinus .(CT Scan Result) There are fractures of the anterior (front) left first, second, and third ribs. During an interview on 10/07/2020 at 9:30 A.M., LPN FF reported that Resident #8 would transfer herself back and forth to the bathroom and her care plan indicated she was able to do so independently. LPN FF reported that after Resident #8 was diagnosed with [REDACTED].#8 was more confused and confused more often. LPN F stated, So many times I thought (Resident #8's) going to fall (because of her oxygen tubing) but she would always move the oxygen tubing (out of the way.) During an interview on 10/07/2020 at 11:50 A.M., Director of Nursing (DON) B reported that she was not made aware of the therapists concerns and changing Resident #8 from Independent to a Stand By Assist. During an interview on 10/7/2020 at 10:53 A.M., Certified Nursing Assistant (CNA) N reported that Resident #8 had had an increase in confusion and weakness since her [DIAGNOSES REDACTED].#8 was care planned to be independent in her room. During an interview on 10/07/2020 at 12:18 P.M., DON B reported care plans are reviewed weekly in the care plan meetings. DON B reported that the Unit Managers and the Floor Nurses are responsible for updating the care plans as needed for any change in condition or new intervention. Resident #46 Review of a Face Sheet revealed Resident #46 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #46, with a reference date of 9/16/20 revealed a Staff Assessment for Mental Status score of 3 indicating Resident #46 was severely cognitively impaired. Review of the Functional Status revealed that Resident #46 required extensive assist of 2 people for bed mobility and transferring. Review of Section M Skin Conditions revealed Resident #46 was at risk for developing pressure ulcers/injuries. Review of Resident #46's Care Plan revealed, I am at a moderate risk for skin impairment, and pressure ulcer development r/t (related to) comfort care immobility and unaware of safety risk. Date Initiated: 06/13/2019 .Pressure Reducing Chair Pad Date Initiated: 06/13/2019. Review of Resident #46's Braden Scale for Predicting Pressure Sore Risk dated 9/10/20 revealed Resident #46 was a moderate risk of developing a pressure ulcer/injury. During an observation on 10/2/20 at 12:27 P.M., Resident #46 was up in her gerichair and did not have a pressure reducing chair pad in place. During an observation on 10/6/20 at 9:30 A.M., Resident #46 was up in her gerichair and did not have a pressure reducing chair pad in place. During an observation on 10/07/20 at 9:02 A.M., Resident #46 was up in her gerichair and did not have a pressure reducing chair pad in place. During an interview on 10/07/2020 at 11:30 A.M., CNA II reported that Resident #46 did not have a pressure reducing chair pad placed in her gerichair. Resident #45 Review of a Face Sheet revealed Resident #45 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #45, with a reference date of 9/9/20 revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated Resident #45 was cognitively impaired. Review of Behaviors-Rejection of Care revealed that the behavior did not exists. Review of Resident #45's Careplan revealed, FOCUS: I require assistance with ADL's .Date Initiated: 6/09/2020. Interventions/Tasks: .I am independent with exercises in the hall, including grabbing the handrail for sit to stand exercises Date Initiated: 09/18/2020 .I am independent for transfers. Date Initiated: 06/09/2020 .AMBULATION: I am independent to ambulate with my four wheeled walker in my room. Date Initiated: 06/09/2020. During an observation and interview on 10/01/20 at 11:15 A.M., Resident #45 was sitting in his easy chair in his room. Resident #45 attempted without success to transfer himself into his wheelchair and stated, .My legs don't wanna hold me up anymore .it's been getting worse and worse since I've been back over here .I used to be able to get my self around .I don't even know why I have that walker anymore .they don't walk me since I've been over here . Resident #45 reported that he had resided on different hall while he was in quarantine for COVID-19 and therapy staff walked him up and down the halls everyday. Resident #45 reported that he likes to go outside once a day and stated, .I go by myself in my wheelchair now .I used to walk with my walker .I can't do it anymore .I wish I could . Resident #45 reported that he would like to have therapy again, and stated, .I haven't had anyone work with me since I've been on this side . During an interview on 10/02/20 at 10:41 A.M., Therapy Director (TD)EE reported that Resident #45 was discharged from therapy a few weeks ago and stated, .it would be our expectation that the CNA's would continue to walk with him so that he stays independent and then refer back to us if there is a decline . Review of a MDS dated [DATE] revealed a Functional Status which indicated the following for Resident #45: Transfer: activity only occurred once or twice .one person physical assist, Walk in room: activity did not occur .ADL activity itself did not occur, Walk in corridor: activity did not occur .ADL activity itself did not occur. During an interview on 10/02/20 at 11:05 A.M., Resident #45 reported that no one has worked with him on this unit and stated, .I used to use that walker all over on the other side of the facility, but not at all over here .they used to come in and work with me in the bed .they don't come here anymore with those weights or anything there was a lady that worked with me with weights and a little game on the other side. Resident #45 went on to say, I haven't walked in the halls .my legs have stopped working since I've been over here .when I was in the other side I used my walker 2-3 times a day walking the length of the hall .but not over here .just my wheelchair. Resident #45 reported that the facility removed his alarm monitors from his bed and chair and stated, I guess they don't think I need them anymore because I don't get up . During an interview on 10/02/20 at 11:15 A.M., CNA CC reported that Resident #45 is not independent in his room and stated .you are supposed to be in the room .he shouldn't be transferring by himself .he is limited assist . During an interview on 10/02/20 at 11:46 A.M., CNA R reported that Resident #45 expects help to get dressed and stated, .a few months ago he was doing it on his own . CNA R reported that Resident #45 needs assistance to transfer and does not use his walker. CNA R reported that she has not walked Resident #45 in the hall and stated, .he was walking a couple months ago . During an observation on 10/06/20 at 09:14 A.M., Resident #45 was observed in his room, sitting in his easy chair, while HA V read scripture to him. Observation of Resident #45's walker parked on a low shelf near the door. No observation of staff offering to walk Resident #45 in the hall. During an interview on 10/06/20 at 09:16 A.M., CNA K reported that Resident #45 does not use his walker independently in his room. During an interview on 10/07/20 at 12:27 P.M., CNA X reported that Resident #45's is able to pull himself up to standing with the bar during a shower and stated, .I have noticed him not being able to stand for as long recently .
F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the necessary restorative nursing services to maintain physical level of function for 1 of 13 residents (Resident #45) reviewed for care, resulting in an avoidable decline in walking and physical movement and the potential for further decline. Findings include: Review of a facility policy Restorative therapy last revised 2/2020 revealed, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level Guidelines: .2. The intra-disciplinary team will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessments, goals, and preferences. 3. Nursing personnel are trained on basic, or maintenance, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight. This training may include, but is not limited to: .c. Encouraging residents to maintain active in assisting with any exercises according to the plan of care. d. Promoting independence in ADLs (activity of daily living), performing tasks for residents only as needed to ensure completion of tasks. e. Assisting residents in adjustments to their disabilities and use of any assistance devices. f. Assisting residents with range of motion exercises, performing passive range of motion motion for residents who lack active range of motion ability . 4. Residents will receive maintenance restorative nursing services as described above, as needed, by certified nursing assistance. 5. The restorative nurse and restorative AIDS receive additional training on restorative nursing program activities upon higher and as needed. 6. Residents, as identified during the comprehensive assessment

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F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) process, will receive services from restorative aides when they are assessed to have a need for such services. These services may include but are not limited to: a. Passive or active range of motion d. Training and skill practice in transfers or walking. e. Training and skill practice in dressing and/or grooming .9. A restorative nurse is responsible for maintaining a current list of residents that require restorative nursing services, and for ensuring that all elements of each resident's program are implemented. .10. A resident's restorative nursing plan will include: a. The problem, need, or strength the restorative tasks are to address. b. The type of activity to be performed. c. Frequency of activities. d. Duration of activities. e. Measurable goal and target date. 11. The discharging therapist, restorative nurse, or designated licensed nurse will communicate to the appropriate restorative aid, the provisions of the residence restorative nursing plan, providing any necessary training to carry out the plan. 12. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the restorative aid documentation form. 13. The restorative nurse, or designated licensed nurse, will provide oversight of the restorative aid activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly . Review of a Face Sheet revealed Resident #45 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #45, with a reference date of 9/9/20 revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated Resident #45 was cognitively impaired. Review of Behaviors-Rejection of Care revealed that the behavior did not exists. Review of Resident #45's Careplan revealed, FOCUS: I require assistance with ADL's .Date Initiated: 6/09/2020. Goal: My functional level will improve on next review Date Initiated: 06/09/2020 .Interventions/Tasks: Functional Maintenance Program: Ambulation >/= 150 feet x2 with 4 wheeled walker and stand by assist , AROM (active range of motion) BUE (bilateral upper extremity) with 4# wt- in all planes, Lower extremities Ergometer x15 minutes, Upper and lower body dressing independently Date Initiated: 09/11/2020. During an observation on 09/30/20 at 02:49 P.M. Resident #45 was sitting in his easy chair in his room. Hospitality Aide (HA) V observed reading scripture to Resident #45. No observation of staff offering to walk Resident #45. During an observation and interview on 10/01/20 at 11:15 A.M., Resident #45 was sitting in his easy chair in his room. Resident #45 attempted without success to transfer himself into his wheelchair and stated, .My legs don't wanna hold me up anymore .it's been getting worse and worse since I've been back over here .I used to be able to get my self around .I don't even know why I have that walker anymore .they don't walk me since I've been over here . Resident #45 reported that he had resided on different hall while he was in quarantine for COVID-19 and therapy staff walked him up and down the halls everyday. Resident #45 reported that he likes to go outside once a day and stated, .I go by myself in my wheelchair now .I used to walk with my walker .I can't do it anymore .I wish I could . Resident #45 reported that he would like to have therapy again, and stated, .I haven't had anyone work with me since I've been on this side . Review of Resident #45's Census in his medical record indicated that he was on 300 hall (COVID-19 unit) on 8/21/20 and then on 100 hall (current hall) on 9/1/20. During an interview on 10/02/20 at 10:41 A.M., Therapy Director (TD) EE reported that Resident #45 was no longer on therapy case load and stated, .he should have a functional maintenance restorative plan .CNA's provide restorative therapy . TD EE reported that Resident #45 was discharged from therapy a few weeks ago and at that time he was independent in his room with his walker and was walking 350 feet in the hall with his walker with supervision. TD EE stated, his last therapy was while he had COVID .he came out of therapy at a slightly higher functioning then before .it would be our expectation that the CNA's would continue to walk with him so that he stays independent and then refer back to us if there is a decline . Review of Resident #45's Physical Therapy Discharge Summary dated 9/2/20 revealed, Goals: .will exhibit normalized gait pattern while safely ambulating on level surface 300 feet with stand by assist (SBA) using assistive device .Discharge: 350 feet SBA . will safely perform functional transfers with independence .Discharge: Met on 8/27/20 .Discharge status and Recommendations: .Prognosis to Maintain CLOF (current level of function) = Excellent with participation in RNP (restorative nursing program) .RNP/FMP (functional maintenance program): To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with IDT: Ambulation. Review of a MDS dated [DATE] revealed, Functional Status indicated the following for Resident #45: Transfer: activity only occurred once or twice .one person physical assist, Walk in room: activity did not occur .ADL activity itself did not occur, Walk in corridor: activity did not occur .ADL activity itself did not occur. During an interview on 10/02/20 at 11:05 A.M., Resident #45 reported that no one has worked with him on this unit and stated, .I used to use that walker all over on the other side of the facility, but not at all over here .they used to come in and work with me in the bed .they don't come here anymore with those weights or anything there was a lady that worked with me with weights and a little game on the other side. Resident #45 went on to say, I haven't walked in the halls .my legs have stopped working since I've been over here .when I was in the other side I used my walker 2-3 times a day walking the length of the hall .but not over here .just my wheelchair. Resident #45 reported that the facility removed his alarm monitors from his bed and chair and stated, I guess they don't think I need them anymore because I don't get up . During an interview on 10/02/20 at 11:15 A.M., CNA CC reported that Resident #45 is not independent in his room and stated .you are supposed to be in the room .he shouldn't be transferring by himself .he is limited assist . CNA CC reported that she had not worked with Resident #45 for a couple weeks, and stated, I am not sure what he is able to do now .when he was on the other side he walked with his walker . CNA CC reported that she has not performed Range of Motion (ROM) exercises with Resident #45 and stated, .if he is care planned to have weights they would be in his room .therapy will provide that . During an interview on 10/02/20 at 11:46 A.M., CNA R reported that Resident #45 expects help to get dressed and stated, .a few months ago he was doing it on his own . CNA R reported that Resident #45 needs assistance to transfer and does not use his walker. CNA R reported that she has not walked Resident #45 in the hall and stated, .he was walking a couple months ago . During an observation on 10/02/20 at 12:27 P.M., Resident #45 was observed ambulating himself in his wheelchair down the hall, then stopped at the end and spent a few minutes looking outside through the big windows. No observation of staff offering to walk Resident #45 in the hall. During an observation on 10/06/20 at 09:14 A.M., Resident #45 was observed in his room, sitting in his easy chair, while HA V read scripture to him. Observation of Resident #45's walker parked on a low shelf near the door. No observation of staff offering to walk Resident #45 in the hall. During an interview on 10/06/20 at 09:16 A.M., CNA K reported that Resident #45 does not use his walker independently in his room. During an interview on 10/07/20 at 12:27 P.M., CNA X reported that Resident #45's is able to pull himself up to standing with the bar during a shower and stated, .I have noticed him not being able to stand for as long recently . During an interview on 10/07/20 at 10:08 A.M., Resident #45 was sitting in his easy chair in his room and stated, .I am great .they even got me up and walked in the hall today .I walked half way down .I am going to try again later today .one of the ladies asked me .
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** Based on observation, interview, and record review, the facility failed to prevent facility acquired deep tissue pressure injury and provide pressure ulcer preventative care and treatment consistent with professional standards of practice for 2 out of 13 residents (Resident #1 and #27) reviewed for the risk of and/or the development of pressure injuries, resulting in the development of an avoidable deep tissue pressure injury for Resident #1 and the potential for skin breakdown and overall deterioration in health status for both residents. Findings include: Review of a facility policy Skin: Assessment, Prevention, and Wound Management last revised 12/2018 revealed, Policy: to provide guidelines for skin assessments, measures to help maintain skin integrity, and management for impaired skin integrity. Procedures: Nursing will follow the national pressure ulcer advisory panel (NPUAP) terms and definitions with PU (pressure ulcer)/PI (pressure injury) assessment, prevention and treatment. All procedures will be followed through by the wound nurse/nurse supervisor upon admission/readmission/newly observed non-pressure or pressure wounds. Procedure: 1. Within eight hours of admission/readmission, weekly, after skin incident, and with significant change in status. The wound nurse/nurse supervisor will perform a head to toe skin assessment. The findings of the assessment will be documented in the residence medical record. 2. The CNA (Certified Nursing Assistant) will observe skin on all residents during care and report any new skin issues to the nurse supervisor. The nurse supervisor will assess the areas and report skin issues to the wound nurse. 3. The CNA/shower aid will perform a thorough skin observation with showers/baths and complete the CNA shower alert form then sign and hand off the form to the nurse supervisor. The nurse supervisor will review the form and assess any skin issues noted and report skin issues to the wound nurse, and document any findings in the medical record. 4. The wound nurse/nurse supervisor will perform a thorough head to toe skin assessment weekly on all residents and document in the residence medical record. Prevention: 1. Within eight hours of admission/readmission the wound nurse/nurse supervisor will complete a Braden evaluation with head to toe skin assessment, then weekly for the first four weeks after admission, monthly and when

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	235352	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASS COUNTY MEDICAL CARE FACIL	23770 HOSPITAL ST CASSOPOLIS, MI 49031

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) there is a change in residence condition or skin incident. 2. Based on the Braden evaluation and a resident admission assessment. The wound nurse/nurse supervisor will develop a resident specific care plan for pressure prevention, pressure injury or pressure ulcer. 3. The wound nurse/nurse supervisor will update the care plan with resident specific interventions as needed . Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, Positioning interventions reduce pressure and shearing force to the skin. Elevating the head of the bed to 30 degrees or less decreases the chance of pressure ulcer development from shearing forces .patient's need repositioning on a schedule of at least every 2 hours . Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 1196-1197 According to the MDS 3.0 RAI Manual, October 2017, DEEP TISSUE INJURY: Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment. Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. Resident #1 Review of an Admission Record revealed Resident #1 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED].#1, with a reference date of 9/23/20 indicating Functional Status revealed that Resident #1 required maximum assistance from 2 or more persons for bed mobility. Review of MDS assessment on 9/28/20 revealed Resident #1 was at risk for pressure ulcer and had 0 unhealed pressure ulcers. Review of Resident #1's Careplan revealed, Focus: I am at risk for skin breakdown r/t (related to) end of life care comfort care measures, memory loss, general weakness, and end of life. Date Initiated: 09/23/2020. Goal: I will maintain intact skin within the limits of disease process and end of life care. Date Initiated: 09/23/2020. Interventions/Tasks: Provide gentle turn and reposition frequently. Date Initiated: 10/01/2020. Skin protectant to buttocks, heels and bony prominences every shift. Date Initiated: 09/23/2020. Monitor and report signs of skin breakdown to Nurse. Date Initiated: 09/23/2020. During an observation on 09/30/20 at 02:41 P.M., Resident #1 was lying on his back side in his bed, with the Head of the bed (HOB) at 30-45 degrees. No pillows observed aiding in repositioning. During an observation on 10/01/20 at 10:43 A.M., Resident #1 was lying on his back side in his bed with the HOB at 45 degrees. No pillows observed aiding in repositioning. During an observation on 10/01/20 at 01:44 P.M., Resident #1 was lying on his back in his bed with the HOB at 45 degrees. No pillows observed aiding in repositioning. During an observation on 10/2/20 at 10:11 A.M., Resident #1 was lying on his back in his bed with the HOB at 45 degrees, flat pillow observed tucked under left trunk. During an interview on 10/02/20 at 10:22 A.M., Licensed Practical Nurse (LPN)/Wound Nurse (WN) W reported that Resident #1 is currently comfort care for end of life and stated, .we do PRN (as needed) suctioning and keep him comfortable . During an interview on 10/02/20 at 10:25 A.M., Certified Nursing Assistant (CNA) R reported that she would be providing care and repositioning for Resident #1 soon. During an observation on 10/02/20 from 11:24 A.M., Resident #1 was lying on his back side in his bed with the HOB at 45 degrees and a flat pillow observed tuck under his left trunk as previously observed at 10:11 A.M. During an interview on 10/02/20 at 11:49 A.M., regarding when Resident #1 would be provided care, CNA R stated, .I have not been in there yet .two of us need to be in there .and the other girl is on break . During an observation on 10/02/20 at 12:15 P.M., Resident #1 observed lying in his bed, on his back side, with HOB at 45 degrees and a flat pillow observed on his left side. During an observation on 10/02/20 at 12:24 P.M., Resident #1 observed lying in his bed, on his back side, with HOB at 45 degrees and a flat pillow observed on his left side. During an observation on 10/02/20 at 1:02 P.M., Resident #1 observed lying in his bed, on his back side, with HOB at 45 degrees and a flat pillow observed on his left side. During an observation on 10/02/20 at 1:22 P.M., Resident #1 observed lying in his bed, on his back side, with HOB at 45 degrees and a flat pillow observed on his left side. During an observation on 10/02/20 at 1:25 P.M., CNA R and CNA CC entered Resident #1's room to perform care. Flat pillows were observed and removed from the right and left side of Resident #1's trunk. CNA CC stated, .these pillows are flat and don't do anything . Observed staff perform an upper body bed bath and then position Resident #1 on his left side to wash his back side. Observation of a large white and pink foam dressing (approximately 5 x 5) covering the entire coccyx area. CNA CC stated, .I've never seen a dressing like that .I can't even put the barrier cream on . Observation of bandage revealed that there was not a date indicating when the bandage was applied. During an interview on 10/2/20 at 1:50 P.M., LPN/WN W reported that she was not aware of Resident #1 having a dressing on his bottom and there were no current orders treatment. LPN/WN W stated, .it sounds like something the hospital would have put on him .he came back to the facility last week .I will look in to it . During an interview on 10/02/20 at 02:30 P.M., LPN O and CNA CC were present. LPN O reported that Resident #1 does not have orders for a dressing on his bottom and is currently only receiving a barrier cream treatment and stated , .the CNA applies the cream .we just verbally verify that it is done . CNA CC then stated, .we can't put a cream on .his whole bottom is covered by a patch . LPN O reported that she was not aware that Resident #1 had a dressing on his bottom. Review of Resident #1's Treatment Administration Record (TAR) from September 2020 and October 2020, as of 10/2/20 at 2:47 P.M., did not reveal orders for a dressing to be applied to the coccyx. Review of Resident #1's Orders dated 10/1/20 revealed, .Skin protectant to buttocks every shift. every shift for preventative . Note that these orders did not indicate a dressing to the coccyx. During an interview and observation on 10/02/20 at 02:36 P.M., Resident #1 was in his bed re-positioned on his right side by LPN/WN W. Observed a large white and pink foam dressing on Resident #1's bottom. LPN/WN W attempted to remove the dressing, and when she touched the dressing it detached from Resident #1's skin without any effort from LPN/WN W. Red skin with deep red wrinkles observed over entire coccyx and purple linear area of discoloration approximately 4 inches long outlining the shape of the dressing was observed on Resident #1's left buttock. LPN/WN W stated, .I think he is getting some deep tissue injury there .I am concerned that the dressing shifted and caused creasing of his skin . LPN/WN W reported that this specific dressing was not one that is kept in stock at the facility and therefore was unable to provide a precise identification for the dressing. LPN/WN W reported that since there was no date or initials on the dressing, and no documentation in the record, she would need to talk to staff to determine when the dressing was applied. During an interview on 10/02/20 at 02:57 P.M., LPN D reported that Resident #1 had returned from the hospital with a preventative dressing on his bottom and it was still in place the next day when she received report and stated, .dressing are initialed and dated when we apply them and there was no date on the one he came back with . LPN D reported that she worked last night and stated, .the girls didn't report anything to me (regarding Resident #1) .he has orders for cream which the CNA's apply .I was not in the room when they applied it . During an interview on 10/02/20 at 03:41 P.M., LPN/WN W reported that she removed a foam dressing covering Resident #1's coccyx when he returned from the hospital on [DATE] and stated, .at that time there were no issues .the deep tissue injury was not there then . During an interview on 10/02/20 at 03:32 P.M., LPN S reported that she was assigned to Resident #1 when he readmitted from the hospital on [DATE] but did not visualize his bottom during his re-admission assessment. Attempts were made on 10/6/20 and 10/7/20 to interview LPN/WN W regarding follow up to indicate when the dressing (that was discovered on 10/2/20) was applied to Resident #1's bottom. During an interview on 10/07/20 at 11:32 A.M., Director of Nursing (DON) B reported on behalf of LPN/WN W and stated, we were unable to determine who put the dressing on (Resident #1) or when it was applied. Review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 9/23/20 at 16:21 (4:21 P.M.) revealed, Moderate Risk: 14 .Sensory perception: Slightly limited .Moisture: Rarely moist .Activity: Chairfast .Mobility: Very limited .Nutrition: Very poor .Friction & Shear: Potential problem. Review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 9/30/20 at 19:53 (7:53 P.M.) revealed, High Risk: 10 .Sensory perception: Very limited .Moisture: Occasionally moist .Activity: Bedfast .Mobility: Very limited .Nutrition: Very poor .Friction & Shear: Problem. During an interview on 10/07/20 at 11:41 A.M., DON B reported that the nurses are using the Braden Scale tool as documentation of the resident's skin assessment. DON B reported that skin assessments are completed once a month, unless the CNA's report a new skin concern. DON B reported that Resident #1's Braden Scale tool documents did not accurately reflect the residents risk for pressure sores. DON B reported that a skin assessment should be performed and the findings documented by the nurse, but at this the facility does not currently have a policy for more than once a month. Resident #27 Review of an Admission Record revealed Resident #27 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 8/12/20 revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #27 was cognitively impaired. Review of the Functional Status revealed that Resident #27 required extensive assistance of one person for mobility in bed. Review of Resident #27's Careplan revealed, FOCUS: I am at moderate risk for skin breakdown related to cognitive loss, vision loss, immobility, incontinence, disease processes, prolonged periods in bed .Date Initiated: 12/26/2018. Goal: My skin will remain free from breakdown thru the next review date. Date Initiated: 12/26/2018. Interventions/Tasks: Apply skin protectant every shift. Date Initiated: 12/26/2018. Apply

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	235352	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) zinc paste to buttock Q (every) shift for prevention. Date Initiated: 10/01/2020. Apply [MEDICATION NAME] to R (right) side of buttock shearing Q shift until resolved. Date Initiated: 10/01/2020 .Turn & re-position every hour. Date Initiated: 08/23/2019. FOCUS: I am at risk for skin breakdown due to Braden score, preference to remain in bed, immobility, and incontinence. Date Initiated: 08/03/2020. Goal: I will have intact skin, free of redness, blisters or discoloration by/through review date. Date Initiated: 08/03/2020. Interventions/Tasks: .Skin protectant to buttocks every shift Date Initiated: 08/03/2020. During an observation on 09/30/20 at 12:03 P.M., Resident #27 was observed lying in her bed, on her back with HOB at approximately 45 degrees, with her lunch tray on the table over her bed. During an observation on 9/30/20 at 2:20 P.M., Resident #27 was observed lying in her bed on her back with HOB at approximately 45 degrees. During an interview on 10/01/20 at 10:12 A.M., CNA Z reported that Resident #27 does not get out of bed and has not for the past year and stated, .she is one that we turn hourly and monitor for pressure ulcers . During an observation on 10/01/20 at 10:12 A.M., Resident #27 was observed lying in her bed, on her back, with a pillow observed on the left side of the bed and the HOB at approximately 20 degrees. During an interview and observation on 10/01/20 at 11:27 A.M., Resident #27 was lying in her bed, CNA HH was performing a bed bath and incontinence care. CNA HH positioned Resident #27 on her left side and removed a soiled brief. Observation of Resident #27's buttocks revealed, a small open area approximately the size of a dime located on Resident #27's left coccyx area. Observation of CNA HH rubbing a white cream directly on the open area, and no cream on the rest of Resident #27's buttocks. CNA HH finished care and positioned Resident #27 on her right side, using a pillow and placing it under her left hip. Note that this was the same position that Resident #27 was in during the previous observation. During an interview on 10/1/20 at 11:27 A.M., CNA HH reported that the open area on Resident #27's coccyx was not a new issue and stated, .I try to put a little barrier cream on her spot .it's barely anything .she does not get cream anywhere else on her bottom . Review of Resident #27's Orders on 10/7/20 at 11:22 A.M. revealed, .Apply [MEDICATION NAME] to R (right) side of buttock Q (every) shift. every shift for shearing area Verbal Active 10/01/2020 Apply skin protectant to heels, buttocks, and bony prominences every shift. every shift for skin care Phone Active 02/21/2020 . Hourly repositioning provided every shift for skin prevention Verbal Active 08/18/2020. During an observation and interview on 10/07/20 at 09:56 A.M., Resident #27 was lying in her bed and was observed to be repositioned on her left side by CNA Z. CNA Z pointed to the area on Resident #27's left buttock and stated, we are using the white barrier and a zinc ointment .the spot was considered a shearing . Review of Resident #27's Skin/Wound Note dated 10/1/2020 at 14:27 (2:27 P.M.) revealed, Res (resident's)buttocks is assessed, noted is a small area to R (right) side of buttock that is blanch-able with depth less than 0.1 Area is undefined and presents as shearing. Res voices no discomfort. Reminder of the importance of turning and repositioning provided. New order received for [MEDICATION NAME] Q (every) shift until resolved. Will continue with preventative plan of skin protectant as res prefers to spend long periods of time in bed. NOTE: this document references the skin/wound location incorrectly as right side of buttock. Review of Resident #27's Skin/Wound Note dated 10/5/2020 at 16:30 (4:30 P.M.) revealed, Buttocks is assessed. ALl skin is intact with out concern. Shearing area is resolved. Continue with zinc past Q shift for prevention . During an interview on 10/07/20 at 12:15 P.M., DON B provided CNA Shower Alert Forms for Resident #27 and reported that the CNA's should note on these sheets any skin concerns. Review of the form dated 9/29/20 did not indicate any areas of concern on the body diagram. Review of the form dated 10/1/20 indicated a skin concern on Resident #27's middle coccyx, noted by a circle drawn on the body diagram by the CNA. Note: this document referenced the location of the skin concern incorrectly on the middle coccyx.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview, and record review, the facility failed to properly store medications in 1 out of 3 medications carts, resulting in the potential for decreased efficacy of medications and the potential for the misappropriation of medication. Findings include: Review of the facility policy, Medication Storage Policy dated 10/14/19 revealed, Policy: It is the policy of the (facility) to ensure all medications housed here will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication room) under proper temperature controls .2. Narcotics and Controlled Substances: A. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key on med carts and in the med room .6. Unused medications: [REDACTED]. These medications are destroyed in accordance to the guidelines of our policy. During an observation on 9/30/20 at 11:46 A.M., the 100 Unit Medication Cart contained a Wixela inhaler with the expiration date of 9/23/20 and the narcotic box was unlocked. During an interview on 9/30/20 at 11:46 A.M., Licensed Practical Nurse (LPN) I reported that that inhaler should have been discarded after the expiration date and the narcotic box should have been locked. During an interview on 10/7/20 at 10:15 A.M., LPN T reported that the narcotic box in medications should be locked if the nurse is not utilizing it. LPN T reported that all narcotics must be double locked.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the accuracy of the documentation of the skin injuries for 2 of 13 residents (Resident #1 and #27) reviewed for accurate and complete medical records, resulting in the potential for inappropriate follow up care, lack of continued assessment, and worsening of the skin injury. Findings include: According to Legal and Ethical Issues in Nursing, 4th Edition, (Guido, G, 2006), a major responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure, patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete. Resident #1 Review of an Admission Record revealed Resident #1 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED].#1, with a reference date of 9/23/20 indicating Functional Status revealed that Resident #1 required maximum assistance from 2 or more persons for bed mobility. Review of MDS assessment on 9/28/20 revealed Resident #1 was at risk for pressure ulcer and had 0 unhealed pressure ulcers. During an observation on 10/02/20 at 1:25 P.M., CNA R and CNA CC entered Resident #1's room to perform care. Flat pillows were observed and removed from the right and left side of Resident #1's trunk. CNA CC stated, .these pillows are flat and don't do anything . Observed staff perform an upper body bed bath and then position Resident #1 on his left side to wash his back side. Observation of a large white and pink foam dressing (approximately 5 x 5) covering the entire coccyx area. CNA CC stated, .I've never seen a dressing like that .I can't even put the barrier cream on . Observation of bandage revealed that there was not a date indicating when the bandage was applied. During an interview on 10/2/20 at 1:50 P.M., LPN/WN W reported that she was not aware of Resident #1 having a dressing on his bottom and there were no current orders treatment. LPN/WN W stated, .it sounds like something the hospital would have put on him .he came back to the facility last week .I will look in to it . During an interview on 10/02/20 at 02:30 P.M., LPN O and CNA CC were present. LPN O reported that Resident #1 does not have orders for a dressing on his bottom and is currently only receiving a barrier cream treatment and stated , .the CNA applies the cream .we just verbally verify that it is done . CNA CC then stated, .we can't put a cream on .his whole bottom is covered by a patch . LPN O reported that she was not aware that Resident #1 had a dressing on his bottom. Review of Resident #1's Treatment Administration Record (TAR) from September 2020 and October 2020, as of 10/2/20 at 2:47 P.M., did not reveal orders for a dressing to be applied to the coccyx. Review of Resident #1's Orders dated 10/1/20 revealed, .Skin protectant to buttocks every shift. every shift for preventative . Note that these orders did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235352	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASS COUNTY MEDICAL CARE FACIL	23770 HOSPITAL ST CASSOPOLIS, MI 49031

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) indicate a dressing to the coccyx. During an interview and observation on 10/02/20 at 02:36 P.M., Resident #1 was in his bed re-positioned on his right side by LPN/WN W. Observed a large white and pink foam dressing on Resident #1's bottom. LPN/WN W attempted to remove the dressing, and when she touched the dressing it detached from Resident #1's skin without any effort from LPN/WN W. Red skin with deep red wrinkles observed over entire coccyx and purple linear area of discoloration approximately 4 inches long outlining the shape of the dressing was observed on Resident #1's left buttock. LPN/WN W stated, .I think he is getting some deep tissue injury there .I am concerned that the dressing shifted and caused creasing of his skin . LPN/WN W reported that this specific dressing was not one that is kept in stock at the facility and therefore was unable to provide a precise identification for the dressing. LPN/WN W reported that since there was no date or initials on the dressing, and no documentation in the record, she would need to talk to staff to determine when the dressing was applied. During an interview on 10/02/20 at 02:57 P.M., LPN D reported that Resident #1 had returned from the hospital with a preventative dressing on his bottom and it was still in place the next day when she received report and stated, .dressing are initialed and dated when we apply them and there was no date on the one he came back with . LPN D reported that she worked last night and stated, .the girls didn't report anything to me (regarding Resident #1) .he has orders for cream which the CNA's apply .I was not in the room when they applied it . During an interview on 10/02/20 at 03:41 P.M., LPN/WN W reported that she removed a foam dressing covering Resident #1's coccyx when he returned from the hospital on [DATE] and stated, .at that time there were no issues .the deep tissue injury was not there then . During an interview on 10/02/20 at 03:32 P.M., LPN S reported that she was assigned to Resident #1 when he readmitted from the hospital on [DATE] but did not visualize his bottom during his re-admission assessment. Attempts were made on 10/6/20 and 10/7/20 to interview LPN/WN W regarding follow up to indicate when the dressing (that was discovered on 10/2/20) was applied to Resident #1's bottom. During an interview on 10/07/20 at 11:32 A.M., Director of Nursing (DON) B reported on behalf of LPN/WN W and stated, we were unable to determine who put the dressing on (Resident #1) or when it was applied. Review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 9/23/20 at 16:21 (4:21 P.M.) revealed, Moderate Risk: 14 .Sensory perception: Slightly limited .Moisture: Rarely moist .Activity: Chairfast .Mobility: Very limited .Nutrition: Very poor .Friction & Shear: Potential problem. Review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 9/30/20 at 19:53 (7:53 P.M.) revealed, High Risk: 10 .Sensory perception: Very limited .Moisture: Occasionally moist .Activity: Bedfast .Mobility: Very limited .Nutrition: Very poor .Friction & Shear: Problem. During an interview on 10/07/20 at 11:41 A.M., DON B reported that the nurses are using the Braden Scale tool as documentation of the resident's skin assessment. DON B reported that skin assessments are completed once a month, unless the CNA's report a new skin concern. DON B reported that Resident #1's Braden Scale tool documents did not accurately reflect the residents risk for pressure sores. DON B reported that a skin assessment should be performed and the findings documented by the nurse, but at this the facility does not currently have a policy for more than once a month. Resident #27 Review of an Admission Record revealed Resident #27 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 8/12/20 revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #27 was cognitively impaired. Review of the Functional Status revealed that Resident #27 required extensive assistance of one person for mobility in bed. Review of Resident #27's Careplan revealed, FOCUS: I am at moderate risk for skin breakdown related to cognitive loss, vision loss, immobility, incontinence, disease processes, prolonged periods in bed .Date Initiated: 12/26/2018. Goal: My skin will remain free from breakdown thru the next review date. Date Initiated: 12/26/2018. Interventions/Tasks: Apply skin protectant every shift. Date Initiated: 12/26/2018. Apply zinc paste to buttock Q (every) shift for prevention. Date Initiated: 10/01/2020. Apply [MEDICATION NAME] to R (right) side of buttock shearing Q shift until resolved. Date Initiated: 10/01/2020 .Turn & re-position every hour. Date Initiated: 08/23/2019. FOCUS: I am at risk for skin breakdown due to Braden score, preference to remain in bed, immobility, and incontinence. Date Initiated: 08/03/2020. Goal: I will have intact skin, free of redness, blisters or discoloration by/through review date. Date Initiated: 08/03/2020. Interventions/Tasks: .Skin protectant to buttocks every shift Date Initiated: 08/03/2020. During an interview and observation on 10/01/20 at 11:27 A.M., Resident #27 was lying in her bed, CNA HH was performing a bed bath and incontinence care. CNA HH positioned Resident #27 on her left side and removed a soiled brief. Observation of Resident #27's buttocks revealed, a small open area approximately the size of a dime located on Resident #27's left coccyx area. Observation of CNA HH rubbing a white cream directly on the open area, and no cream on the rest of Resident #27's buttocks. During an interview on 10/1/20 at 11:27 A.M., CNA HH reported that the open area on Resident #27's coccyx was not a new issue and stated, .I try to put a little barrier cream on her spot .it's barely anything .she does not get cream anywhere else on her bottom . Review of Resident #27's Orders on 10/7/20 at 11:22 A.M. revealed, .Apply [MEDICATION NAME] to R (right) side of buttock Q (every) shift. every shift for shearing area Verbal Active 10/01/2020 Apply skin protectant to heels, buttocks, and bony prominences every shift. every shift for skin care Phone Active 02/21/2020 . Hourly repositioning provided every shift for skin prevention Verbal Active 08/18/2020. Note: this order references the shearing area incorrectly as the right buttock. During an observation and interview on 10/07/20 at 09:56 A.M., Resident #27 was lying in her bed and was observed to be repositioned on her left side by CNA Z. CNA Z pointed to the area on Resident #27's left buttock and stated, we are using the white barrier and a zinc ointment .the spot was considered a shearing . Review of Resident #27's Skin/Wound Note dated 10/1/2020 at 14:27 (2:27 P.M.) revealed, Res (resident's)buttocks is assessed, noted is a small area to R (right) side of buttock that is blanch-able with depth less than 0.1 Area is undefined and presents as shearing. Res voices no discomfort. Reminder of the importance of turning and repositioning provided. New order received for [MEDICATION NAME] Q (every) shift until resolved. 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