STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235016	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLEGRA NURSING AND REHAB	**434 W NORTH ST JACKSON, MI 49202**

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 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake #MI 707. Based on interview and record review, the facility failed to correctly identify one resident (#1) out of one resident reviewed for transfer to a local hospital to the emergency response crew (EMS), the attending physician, and to the local hospital resulting in the likelihood that the resident would experience fear that she would not be cared for appropriately by the EMS crew, the attending physician and by the local hospital. Findings include: Resident #1 (R1) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R1 had a score of 6 out of a possible 15 points on the Brief Interview for Mental Status (BIMS) evaluation indicating severe cognitive deficit. According to her Minimal Data Set (MDS) information, R1 needed extensive assistance with all activities of daily living. R1 did not walk. On 3/12/20 at 9:20 AM, the complainant M was interviewed. During the interview, the complainant M stated her mother, R1, was admitted to the facility as a Virginia Doe as the facility did not send the correct paperwork to the local hospital and the hospital did not know R1's identity. On 3/12/20, a record review of the treatment notes for R1 from the local hospital were reviewed. In the beginning of the documentation the noted referred to R1 as a [AGE] year old female and referred to her as Virginia. As documentation continued, R1's real name was incorporated into the notes. On 3/12/20 at 11:00 AM, certified nursing assistant (CENA) C was interviewed. CENA C stated Licensed Practical Nurse (LPN) E sent the wrong paperwork with R1 when she was transported to the hospital by emergency responders (EMS). On 3/12/20 at 11:10 AM, Registered Nurse (RN) D was interviewed. RN D stated LPN E provided EMS with the paperwork when R1 was to be transferred to the local hospital. R1 was awake and had her eyes open although she did not speak. The paperwork belonged to R1's roommate. RN E stated she observed EMS staff, as they rolled R1 into the elevator, address R1 by her roommate's name. R1 had her eyes open and was looking at EMS staff when they called her by the wrong name. In addition, the roommate's husband was notified incorrectly by LPN E that his wife was being sent to the local hospital emergency room . LPN E had also called the attending physician and the local hospital and gave them R1's roommate's information instead of the correct information related to R1. On 3/12/20 at 12:10 PM, LPN E was interviewed. She stated, when R1 needed to be sent to the hospital, LPN E checked the electronic medical record and accidentally looked at R1's roommate to determine if R1 was to be a full code. R1 was a Do Not Resuscitate (DNR) but the roommate was a full code. LPN E called the wrong resident's family, the attending physician and the local hospital and erroneously informed them that R1's roommate was being sent to the hospital when it was R1 who was going to the local hospital. LPN E was told by the outside lab technician that the wrong paperwork was sent with R1 to the local hospital. LPN E then had to re-call the local hospital, the physician and the roommate's family informing them that R1's roommate had not been sent to the local hospital. R1's family was then notified. The correct information was faxed over to the local hospital.

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