STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235123	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DURAND SENIOR CARE AND REHAB CENTER, L L C	8750 E MONROE RD DURAND, MI 48429

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 0657 **Level of harm -** Minimal harm or potential for 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 is related to intake MI 875 Based on observation, interview and record review the facility failed to revise the Activity of Daily Living care plan for 1 of 7 sampled residents (Resident #2) resulting in, no documented shower/bath/bed baths x 30 days, preferred time frame and scheduled days of showers/baths/bed baths not indicated, no interventions implemented to address documented refusals and/or not scheduled/assigned shower/baths/bed baths, feelings of uncleanliness, and the potential for continued missed shower/bath/bed baths. Findings Include: Resident #2 (R2) On 8/18/20 at 3:50 PM R2 was observed in his room. He was sitting up in his bed, wearing glasses, dressed in a gown, and had a Foley catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage) with yellow urine draining in the tubing. R2 was queried about the frequency of his showers. R2 revealed he preferred to take his showers in the evening at 7:00 PM, whereby there would be occasions when the facility only had 2 Competency Evaluated Nursing Assistants (CENA's) on the floor, that would have issues locating his wheelchair (w/c) to take him down for his shower. R2 revealed his shower days were on Wednesday and Saturday, he did not get his showers regularly as scheduled, and that the last shower he received was about a month ago. When asked how did it make him feel, to not receive his scheduled showers. R2 revealed, it made him dirty and that he should be able to get a shower in the evening. R2 denied refusing shower/baths when asked, revealed once in a while he would get tired during shower time and reschedule it, which occurred last month. Also, that there was a period when his w/c location was unknown, a smaller substitute w/c was used that was uncomfortable, he could not ambulate from his room to the shower room because it made him too tired, and he preferred his w/c to be transported from his room to the shower room. The Electronic Medical Record (EMR) reflected R2 was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. The most recent quarterly Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of 5/26/20 reflected R2 was cognitively intact, and required limited assistance of 1 person for bathing. When reviewing the EMR on 8/19/20 at 8:58 AM under the task tab (where showers/bathing, bed bathing was documented), per the facility's EMR Shower/Bathing/Bed Bath (BB) record for the last 30 days (7/23/20 - 8/19/20) reflected the following: Not Scheduled/Assigned was documented on: 7/23/20 at 2:59 PM by Registered Nurse (RN R) 7/27/20 at 2:59 PM by CENA N 7/30/20 at 10:22 AM by Resident Aide (RA) S 8/02/20 at 10:07 PM by Non Certified Aid (NCA) T 8/06/20 at 2:59 PM by NCA T Refused on: 8/03/20 at 2:59 PM by CENA I 8/10/20 at 12:39 PM by CENA U 8/13/20 at 9:43 AM by CENA U 8/13/20 at 3:19 PM by CENA O 8/17/20 at 10:42 PM by CENA V The Shower/Bath/BB record reviewed on 8/21/20 at 7:30 AM, reflected R2 refused on 8/20/20 at 9:21 PM by CENA W. There was no documentation located in the EMR or provided by the facility prior to exit on 8/21/20, that reflected R2 received a Shower/Bath/BB on the above dates, or a rationale for the missed Shower/Bath/BB dates. The Assistant Director Of Nursing (ADON X) was interviewed on 8/19/20 at 12:32 PM, and was queried as to where CENA's documented the care they provided. ADON X revealed, on the Kardex (plan of care provided for CENA's) that was kept in the Point Of Care (POC: EMR where CENA's documented), which was linked to the Point Click Care (PCC: EMR where nurses documented). When asked what did Not Scheduled/Assigned meant on the Shower/Bath/BB record ADON X revealed, it would mean not their (the resident) scheduled shower day, the resident's shower day was kept in the Kardex, and resident's shower days were kept in the care plan too. When queried about what did Refused on the Shower/Bath/BB record mean, and what were CENA's to do when a resident refused ADON X revealed, it meant the resident refused. Also, that staff were to re-approach and ask the resident if there was a different time they would like to have their shower. When asked how often staff were to re-approach the resident ADON X revealed, 2 to 3 times, the CENA was to document it as well, that they (CENA) should document at least once, that the resident refused and was re-approached. During the Abbreviated Survey facility staff were interviewed onsite and by phone from 8/18/20 to 8/21/20, whom desired to remain anonymous who provided the following responses: Anonymous Staff Person (ASP) #1 was asked what did not scheduled/assigned mean on the Shower/Bath/BB record and revealed, it meant it wasn't scheduled that day, they did not get a shower or bath, and all showers were scheduled in the computer. The staff person revealed they would tell the nurse the shower day needed to be changed, the nurse was the only one who could change the shower days, and that the resident would then get a Shower/Bath/BB on their assigned day. The staff person was then asked what occurred when a resident refused and ASP #1 revealed, they would try to encourage the resident that they needed to get washed. If the resident keep refusing, the staff person would let the nurse know, and continue to encourage the resident to shower/bath/BB often throughout the shift, and put a custom alert in the POC about the refusal. ASP #2 was asked what did not scheduled/assigned mean on the Shower/Bath/BB record and revealed, it meant Shower/Bath/BB was not scheduled for that day or shift. When asked what were they to document ASP #2 revealed, they would inform the nurse, tell them the person did not have a shower and that the POC was incorrect. Also, on the very next scheduled day the resident would get a shower, unless they indicated they wanted one before hand or made it apparent they needed one before hand. When queried as to what refused on the record mean ASP #2 replied, that the resident did not want a shower. When asked what were they to do when that occurred ASP #2 revealed, the resident had the right to refuse. ASP #2 revealed they would ask the resident again 3 times and if refused, have a co-worker ask the resident another 3 times, to see if the resident would take a shower with another person. Lastly, if the resident refused the shower, staff would wash the resident up, and document it as a bed bath in the POC. On 8/21/20 at 8:40 AM the Director Of Nursing (DON B) was interviewed by phone and asked, when giving R2 shower/baths/BB, what were staff to document? DON B revealed a shower, bath, BB, or refusal. DON B revealed, I visited him a few weeks ago and he said No to a shower, and that he wanted it the next day at 7:00 PM. Also, that he let them know what he wants, if R2 refused they would do a BB, staff did head to toe bathing in the morning and night, but that did not include daily hair washing. When asked what did Not Scheduled/Assigned mean on the record DON B revealed, it meant it was not their scheduled day. If it was an prn (as needed), they were to document prn. If a resident verbalized they felt yucky, they would give a prn shower. When asked what were staff to do when a resident refused a shower/bath/BB DON B revealed, staff would re-offer throughout the shift and then do a wash-up if the resident adamantly refused. Staff were to re-approach the resident at least 2-3 times, and go get another person to have them re-approach the resident for a shower/bath/BB, and that R2 had his favorites. DON B was informed that there was no documentation to support R2 was re-approached and/or offered a shower/bath/BB on the missed days reflected on the form. DON B revealed, R2 picked and preferred his shower time of 7:00 PM in the evening, the girls did their best to accommodate him, and that he was scheduled to have a shower 2 times a week. Also, there was no documentation to reflect a conversation had taken place with R2 about the consistent documentation of Not Scheduled/Assigned and Refusals of showers, or a plan of care reflecting how to deal with them. The Activity of Daily Living (ADL) care plan for R2 revised on 10/23/2019 focus reflected: ADL's: Resident is independent with ADL's and may need assistance as needed related to (r/t): frailty. The goal of the care plan reflected: I will not decline with transfers,

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dressing and personal hygiene through next review. Date Initiated: 08/09/2019 Revision on: 05/30/2020. Target Date: 08/28/2020 Interventions for the care plan included: One Assist for showers twice weekly and PRN (as needed). I can wash my upper and lower body with assist as needed. Date Initiated: 02/08/2019 Revision on: 06/11/2020. The ADL care plan, which was the only CP that referred to showers did not indicate R2's preference of having his showers in the evening at 7:00 PM, did not reflect to re-approach the resident if he refused showers, and did not reflect said days of showers that established a routine. The facility's current Bathing -Tub/Shower policy dated 7/1/2018 reflected: PURPOSE: 1. To clean the skin. 2. To provide comfort for the resident 3. To observe the condition of the skin PROCEDURE: 1. Honor resident preference for time and type of bathing.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake MI 875 Based on observation, interview and record review the facility failed to provide showers as ordered for 1 of 7 sampled residents (Resident #2), resulting in feelings of uncleanliness, bathing preference not honored, and the potential for body odor and skin irritation. Findings Include: Resident #2 (R2) On 8/18/20 at 3:50 PM R2 was observed in his room. He was sitting up in his bed, wearing glasses, dressed in a gown, and had a Foley catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage) with yellow urine draining in the tubing. R2 was queried about the frequency of his showers. R2 revealed he preferred to take his showers in the evening at 7:00 PM, whereby there would be occasions when the facility only had 2 Competency Evaluated Nursing Assistants (CENA's) on the floor, that would have issues locating his wheelchair (w/c) to take him down for his shower. R2 revealed his shower days were on Wednesday and Saturday, he did not get his showers regularly as scheduled, and that the last shower he received was about a month ago. When asked how did it make him feel, to not receive his scheduled showers. R2 revealed, it made him dirty and that he should be able to get a shower in the evening. R2 denied refusing shower/baths when asked, revealed once in a while he would get tired during shower time and reschedule it, which occurred last month. Also, that there was a period when his w/c location was unknown, a smaller substitute w/c was used that was uncomfortable, he could not ambulate from his room to the shower room because it made him too tired, and he preferred his w/c to be transported from his room to the shower room. The Electronic Medical Record (EMR) reflected R2 was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. The most recent quarterly Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of 5/26/20 reflected R2 was cognitively intact, and required limited assistance of 1 person for bathing. 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F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 648. Based on observation and interview, the facility failed to distribute drinking water to residents in a sanitary manner for two resident rooms, which included up to four residents, resulting in the potential for cross-contamination. Findings include: During an observation on 8/19/2020 at 11:17 AM, Life Enrichment Aide (LEF) F was observed distributing water to resident rooms on the 500 unit hallway. A rolling cart, constructed of a PVC-type material, was observed to have a cooler with ice, a container with an ice scoop and a water dispenser with a push-button spout. A separate tub/basin was on the cart, below the level of the water dispenser. The tub/basin did not have a drain. During an observation on 8/19/2020 at 11:26 AM, LEF F was observed bringing two styrofoam cups out of room [ROOM NUMBER] and placing

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) them on the rolling cart and on top of the water dispenser. LEF F was observed opening the lids of the cups and pouring water into the tub/basin, which had standing water in it. LEF F then refilled the styrofoam cups with ice and water to distribute back to the residents. At approximately 11:30 AM on 8/19/2020, LEF F was observed taking two styrofoam cups from room [ROOM NUMBER] and placing them on the rolling cart. When queried on the facility process for water pass, LEF F reported they did water pass all over building. LEF F described the process of grabbing the residents cup, dumping out what they had in the cup, refilling the cup and sanitizing (their hands) between rooms. When queried on how they could ensure they were not cross-contaminating with the described process, LEF F reported by washing more in between each room. When asked they were cleaning the cart between placing cups from different rooms on it, LEF F stated they were not. LEF F reported the cart was bleached before each use but not between each resident. When asked how they could ensure they were not splashing water from the tub/basin into the cups when pouring the water into the basin, LEF F reported they were careful and emptied the bin about three times while on the hallway, so it didn't get too full. During an interview on 8/19/2020 at 12:23 PM, Infection Control Nurse (RN) G reported the process for resident water pass was to take the cups out of the rooms, usually one at a time, so that they could maneuver it. If staff teamed up, one person could hold the cup and one could scoop ice. RN G reported that staff should not have placed the (used) cups on the cart or on the water dispensers. RN G reported staff should be very careful when pouring the water out and using the scoop for ice.