STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND OAKS NURSING CENTER	600 DENMARK ST BALDWIN, MI 49304

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI000- 6. Based on interview and record review, the facility failed to assess and supervise one resident's (Resident #1) ability to safely smoke outside, resulting in resident #1 catching fire, suffering second and third degree burns, and subsequently dying from complications of the thermal burns. Findings include: Resident #1 (R1) Review of a Face Sheet revealed R1 was a [AGE] year old female who admitted to the facility on [DATE] with pertinent [DIAGNOSES REDACTED]. Review of a Physician Determination of Decision Making Capabilities, first signature dated 4-22-20 and second signature dated 5-21-20, revealed that R1 was deemed no longer capable of making her own decisions, thus activating the DPOA (durable power of attorney) on record from 11/16/06. The reason given for this determination was BIMS-9. Review of a facility nursing progress note dated 07/06/20, time stamped 17:10, and written by Licensed Practical Nurse (LPN) B divulged Resident was noted to be sitting outside smoking a cigarette. Upon looking outside the window to check on her it was noted that her blouse was on fire. This writer responded immediately calling for CENAs on the hallway to assist. Blouse was pulled off resident before any [MEDICAL CONDITION] result. Hair on the left side of the head noted to be singed, burn marks noted to left side of upper chest, left shoulder, left ear and neck. EMS notified. Wet dressings applied [MEDICAL CONDITION] to EMS leaving with resident. Resident was alert and orientated x 4. Review of an emergency department nursing note dated 07/6/20 at 7:19 P.M., revealed Pt presented to ED [MEDICAL CONDITION] left side of face, ear, lower lip chin, neck, left shoulder, chest, top of left breast, left palm and left fingertips. Blisters noted to chin, ear lobe, left shoulder, left palm and 4 of her left fingertips. Brown, yellow and black discoloration noted to large portion of left anterior chest. Provider at bedside documenting burns. Review of a hospital history and physical for admission disclosed that R1 suffered 5.5% TBSA (total body surface area) 2nd and 3rd [MEDICAL CONDITION] her left shoulder, left hand palm and 4 fingers on the left hand, left chest wall, left side of neck and chin, hair was singed on head and left eye lashes, and left side of face. R1 was admitted to the hospitals burn unit. R1 was pronounced dead at the hospital burn unit on 07/15/20 at 9:01 P.M. Death Certificate indicated cause of death for R1 was accident-medical complications [REDACTED]. Review of R1's complete care plans revealed that R1 did not have a care plan for smoking. Review of Progress Notes for R1 from 06/30/20 to 07/06/20 revealed no documentation related to R1's LOC (level of consciousness), alertness or orientation, nor sleep hygiene or duration of sleep. Review of an Interdisciplinary Note, dated 07/01/20 disclosed the following narrative:R1 has altered mobility and ADL's in relation to her [DIAGNOSES REDACTED]. An expected insidious decline in her condition is unavoidable . Other symptoms that interfere with mobility such as fatigue, [DIAGNOSES REDACTED], dizziness and [MEDICAL CONDITION], numbness, and lack of coordination are to be expected . She is receiving extensive weight-bearing assistance with bed mobility, transfers, clothing management, toilet use, and personal hygiene . (R1) has complaints of pain daily, is prescribed [MEDICATION NAME], and [MEDICATION NAME] sulfate . (R1) is prescribed [MEDICATION NAME] daily for her agitation .(R1) is predisposed to falls and injury in relation to her impaired judgement due to her [DIAGNOSES REDACTED]. During an interview on 07/20/20 at 7:40 P.M., LPN B indicated that residents usually smoke out by the road but with COVID, things were more lenient with smoking and so smoking was allowed outside the door at the end of the hallway. LPN B then indicated that during the late afternoon of July 6th, an aid took R1 out the door at the end of hallway so R1 could smoke. LPN B indicated that R1 was outside, within view of LPN B, and that (the LPN) looked away for just a minute and looked back and saw R1 on fire. LPN 'B stated that she had spoken with Occupational therapist/Therapy Manager (OTR) H earlier that day about whether R1 was capable of going outside to smoke because she was sleepy. LPN B reported seeing R1 outside, before the fire, and R1 appeared to be smoking an unlit cigarette for several minutes. I never saw her (R1) do that before. During an interview on 07/20/20 at 7:51 P.M., Certified Nurse Aid (CNA) G reported working with R1 on July 6th and that R1 was sleepy that day and had been acting really sleepy the past few days. CNA G indicated that while taking R1 outside to smoke, R1 attempted to light the cigarette while in the building. CNA G divulged that she told R1 not to smoke inside and to wait until they got outside to smoke. CNA G also indicated that R1 had not attempted to light a cigarette indoors before (that CNA G was aware of). During a second interview on 07/20/20 at 8:15 P.M., LPN B stated that OTR H asked if it was safe for R1 to be out smoking because R1 was so sleepy. LPN B then indicated that OTR H was told that if R1 can wheel herself down the hallway then R1 was ok to go out and smoke. Review of a facility policy Smoke Free Facility, last revised December 2014, revealed the Procedure: 2. The facility will not provide an outdoor designated smoking area on facility property. The United States Fire Administration has determined- based on data from the National Fire Incident Reporting System, The National Fire Protections Association (NFPA), the National Center for Health Statistics, and the State Fire Marshal's Offices- that by far the leading cause of residential fires that result in fatalities in older adults is smoking. During an interview on 07/21/20 at 11:55 A.M. CNA K indicated working with R1 the morning of July 6th, that R1 was pretty sleepy and tired, and that staff had to help R1 out the side door to smoke. During an interview on 07/22/20 at 9:20 A.M., LPN N stated that a resident who was sedated, lethargic or sleepy should not be allowed outside to smoke. Review of a 15 minute check charting document, dated 07/23/20, for 3 residents residing on Pine hall, revealed that at 10:51 A.M., the last notations were made by staff at 9:30 A.M. Review of a 15 minute check charting document, dated 07/27/20, for 2 residents on Hickory that were listed as fall risks, revealed that at 11:05 A.M., the last notations made by staff were at 9:30 A.M.
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI000- 2. Based on observation, interview, and record review, the facility failed to monitor the hydration status for 1 resident (Resident #5) and failed to make water accessible or offer water regularly to 3 residents (Resident #6, Resident #7, and Resident #8), resulting in the need for emergency care and hospitalization for Resident #5 and the potential for complications of dehydration for Resident's #6, #7, and #8. Findings: Resident #5 (R5) Review of a Face Sheet revealed R5 was a [AGE] year old female, admitted to the facility on [DATE] for rehabilitation and strengthening, with pertinent [DIAGNOSES REDACTED]. Review of a Brief Interview for Mental Status (BIMS) indicated that R5 had severe cognitive impairment. Review of a history and physical, dated 3-24-20, revealed R5 was nonverbal, dependent upon assistance for feeding and was a two person assist. R5 was discharged to another facility on 05/08/20 to be closer to family. Review of a Progress Note dated 04/15/20, indicated staff has to anticipate (R5's) needs. Review of a Progress Note dated 04/16/20, indicated that R5 requires staff assisting with fluids. Review of Progress Note dated 04/24/20, indicated that R5 requires assist with fluids. Review of Progress Note dated 04/27/20, indicated that for R5 fluids encouraged with poor intake this shift. Review of Progress Note dated 04/28/20, indicated that R5's fluid intake poor, encouraged. Review of a Medication Administration Record, [REDACTED]. Order details: [MEDICATION NAME]-sodium chloride solution 5-0.9% 60

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

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) milliliters per hour intravenously every shift to promote hydration 2000 milliliters total. Review of a Short Term Care Plan for Urinary Tract Infection, dated 4/30/20, revealed that the care plan was implemented due to fever, leukocytosis, and overall decline. R5 was prescribed the [MEDICATION NAME] 5 days. Review of the medical records for R5 revealed there was not a short term care plan for the resident while receiving IV fluids. During an interview on 07/27/20 at 10:35 A.M. the administrator indicated not needing a care plan for the administration of IV fluids because we have a doctors order. The administrator also indicated that the facility did not have anything specific for IV fluids or hydration in the short term care plans. Review of the facility policy/procedure Care Planning Process: Admission, Comprehensive & Short Term, last updated 11/2017, revealed the following 3. Care Plans are initiated to address interventions for prevention of functional decline, rehabilitative and restorative care, health maintenance issues, skin care, discharge potential, safety and wandering / exit seeking behavior, nutritional, psychosocial, and comfort. Short Term Care Plans: 1. Short term care plans may be implemented to assist with more intensive specialized limited term needs. Review of a facility Follow Up Question Report, dated 03/20/20-05/08/20, revealed the following fluid intake percentages for R5 at each meal: 5/3/20- dinner- 25% fluids accepted, 5/4/20-dinner-0% fluids accepted (resident refused), 5/6/20-breakfast-0% fluids accepted (resident refused), 5/6/20-lunch-50% fluids accepted, 5/6/20-dinner-25% fluids accepted, 5/7/20-breakfast-0% fluids accepted, 5/7/20-lunch-0% fluids accepted (resident refused), 5/7/20-dinner-25% fluids accepted, 5/8/20-breakfast-50% fluids accepted, 5/8/20-lunch-25% fluids accepted, and 5/8/20-dinner-0% fluids accepted. Review of a Recapitulation of Stay, dated 05/04/20, indicated that R5 does well with liquid nutrition. Review of a Discharge Summary, dated 05/05/20, and completed via telemedicine, indicated that R5 had not been eating or drinking very well, had been losing weight, and was recently treated with an IV (intravenous fluid) for hydration. Staff reported that oral intake was poor. A nurse had reported that R5 had a white coating on the tongue and mucosal membranes. No nursing progress notes were located in the medical record for R5 on 05/06/20, 05/07/20, or 05/08/20. An RD (registered dietician) Review progress note, dated 05/08/20, the date of R5's discharge, was the only progress note located in the medical record on the day of discharge. The Recapitulation of Stay and Discharge Summary had been completed days prior to R5's discharge from the facility: 05/04/20 and 05/05/20 respectively. During an interview on 07/27/20 at 10:48 A.M., the Director of Nursing (DON) reported that after reviewing R5's medical record, the DON could not locate any documentation that described R5's mental status and disposition on 05/08/20, the day of discharge. The DON stated the exact time of R5's discharge from the facility on 05/08/20 was unknown. R5 was discharged to another nursing facility that was closer to family. Review of an ambulance run sheet, dated 05/08/20, indicated that R5 was transported to another facility to be closer to family, however, on arrival to the second facility, R5 was obtunded and unresponsive. R5 was sent to the emergency room for evaluation. Review of hospital records show that R5 was admitted to the emergency room (ER) on 05/08/20 at 10:32 P.M., under the care of doctor W. Review of the initial Physical exam done on R5 by doctor W, completed in theER on [DATE], disclosed the following: Physical Exam Head: Normocephalic and atraumatic. Right Ear: External ear normal. Left Ear: External ear normal. Nose: Nose normal. Parched mucous membranes. No moisture in mouth or nose Additional documentation by doctor W on 05/08/20 in the ER. Due to the nature of this patient's presentation, there were was a high probability of sudden, clinically significant, or life-threatening event which required my emergent intervention and constant monitoring. The patient was reexamined and progress was re-evaluated in response to emergent therapies. Additional documentation regarding R5, by doctor W on 05/09/20 at 2:23 A.M. in the ER. I am doubtful patient persistent is related [MEDICAL CONDITION]. I believe it is more a reflection of profound dehydration with a lactic acidosis of 4.5 sodium of 176 acute renal injury with BUN 95 and creatinine 3.6 Review of an Incident Investigative Report, generated on 05/14/20, and submitted by doctor W disclosed the following: Patient transferred from (nursing home) to (new facility) to be closer to home .upon arrival to (new facility) patient was noted to be obtunded and not responsive. Patient presented to the emergency room . I evaluated the patient. Patient exhibited severe clinical dehydration. Patient's laboratory testing also reflected severe dehydration. Patient's sodium was 176, normal range is 134-146. Patient's kidney function had a BUN of 95 with a creatinine 3.6, normal range for BUN is 8-20 and normal range for creatinine is 0.5-1.1. It is my professional opinion as a family medicine/emergency medicine physician that this individual had no access to free water for several days for the sodium to be as elevated and the kidney functions to be this elevated. This is not the first time I have had patients from this extended care facility show up in the emergency department with extreme and severe dehydration due to lack of water. Patient was not on medications, that in my opinion, would cause such significant dehydration. Review of hospital records divulged the following information on the History and Physical for admission, dated 05/09/20: PHYSICAL EXAMINATION VITAL SIGNS: Temperature 38.4; heart rate on presentation 125, later 93; respirations 24, later 18; blood pressure 129/96, pulse ox 88% on room air, improved to 93% on 2 L. GENERAL: She is disheveled, nonverbal. HEENT: Nasooropharynx, edentulous with severe dry mucous membranes. Dry coating on tongue. NEUROLOGIC: She is lethargic and moans with movement, nonverbal, moves all 4 extremities to pain. LABORATORY DATA Urinalysis with blood, many bacteria, 7 white blood cells. Labs reveal a procalcitonin of 3.04. ABG, 7.41/35/103/97%. I am not clear if that is on 2 L or on room air. [MEDICATION NAME] level low at 37. Ammonia level 22. TSH level is 1.66. White blood count is 15.5, hemoglobin is 15.7, platelets are 244. BUN is 95, creatinine is 3.66. Baseline is normal. Glucose is 314, sodium is 176, [MEDICATION NAME] 20, chloride is 135. Lactic acid is 4.5, repeat is 4.4. Liver enzymes essentially normal. Magnesium 3.1. IMPRESSION 1. Severe dehydration. 2. [MEDICAL CONDITION]. 3. Acute kidney injury. 4. [MEDICAL CONDITION] ? underlying pneumonia LABORATORY DATA Urinalysis with blood, many bacteria, 7 white blood cells. Labs reveal a procalcitonin of 3.04. ABG, 7.41/35/103/97%. I am not clear if that is on 2 L or on room air. [MEDICATION NAME] level low at 37. Ammonia level 22. TSH level is 1.66. White blood count is 15.5, hemoglobin is 15.7, platelets are 244. BUN is 95, creatinine is 3.66. Baseline is normal. Glucose is 314, sodium is 176, [MEDICATION NAME] 20, chloride is 135. Lactic acid is 4.5, repeat is 4.4. Liver enzymes essentially normal. Magnesium 3.1. PLAN: She will be admitted to the hospital. She will be placed on telemetry with serial neurologic exams. She will receive gentle hydration with slow correction of her sodium. She is in no condition to be able to take any oral intake. She will receive an NG tube to get her medications including her [MEDICATION NAME], which is subtherapeutic. We will monitor her renal function. I suspect this is all from dehydration. Review of a Discharge Summary, dated 05/20/20, and dictated by doctor V, revealed the following: 69 y/o (year old) WF(white female) married ECF(extended care facility) resident patient with known PMH (past medical history) of [MEDICAL CONDITION] with significant dementia who is non-verbal and bedridden. She was admitted by Telemedicine on 5/9/2020 for Acute [MEDICAL CONDITION] with severe [MEDICAL CONDITION] (high sodium level), and acute [MEDICAL CONDITION] (damage that affects the brain). She was profoundly dehydrated. She received IVF's (intravenous fluids) to manage the dehydration and [MEDICAL CONDITION]. Her labs were monitored every 3 hours to assist in treating the high sodium, but not too quickly. It took considerable amount of time to resolve the [MEDICAL CONDITION] and the [MEDICAL CONDITION]. She had an NGT (nasogatric tube) tube early on in the admission for free water hydration as well as medication administration. Resident (R6) Review of a Face Sheet revealed R6 was [AGE] year old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS), dated 05/04/20 revealed a score of 7 out of 15 which indicates severe cognitive impairment. During an observation on 07/23/20 at 10:25 A.M., R6 was resting in bed with eyes closed. The bedside table was pushed up to the head of the bed, fluid cup on bedside table, out of reach of R6. Staff entered the room to get R6 up for the day. During an interview on 07/23/20 at 1100 A.M., R6 stated that her mouth was very dry, lips appeared dry and cracked, and she had not yet had anything to drink today. R6 indicated that when staff was just in to get her up for the day, staff did not offer her anything to drink. Fluids remained out of reach of R6 on the bedside table. Review, at 11:15 A.M. on 07/23/20, of an Electronic Medication Administration Record [REDACTED]. Documentation for first shift on 07/23/20, for this order, was already signed off as completed by nursing. During an observation on 07/27/20 at 8:55 A.M. R6 was up and breakfast was on the bedside table out of reach. Call light was wrapped around the bedrail, also out of reach of R6. Observed on the breakfast tray were three 8 ounce cups of fluid, untouched. R6 stated that she was not sure where the food was, I can't see it. R6 also stated that she had ordered eggs and toast for breakfast but must not have gotten the toast. When this surveyor advised R6 that there was toast on the breakfast tray, R6 responded oh really, it's there? R6's mouth and lips appeared dry and cracked. Review of a Care Plan for R6 revealed the FOCUS: (R6) has the potential for altered mobility and ADL's related to: decreased mobility r/t history of left femur fracture with surgical repair, legally blind, hx falls, dementia, non-ambulatory. (R6) has generalized weakness and decreased mobility. (R6) is unable to propel her w/c independently and transfers with mechanical lift and two person assist. She utilizes a tilt in space w/c to promote proper body alignment and improved posturing as well as socialization. Assist rails utilized on bed to promote enhanced bed mobility. Review of a Care Plan for R6 revealed the GOAL: (R6) will be clean, fall risks managed, well groomed, and appropriately dressed, and continue to meet the highest practicable functional

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) independence possible. Review of a Care Plan for R6 revealed the INTERVENTIONS: ASSISTIVE DEVICES: food in bowls, built up silverware, abductor pillow between knees when in bed for hip alignment. Clip call light to (R6's) shirt as she desires. Keep bedside table near her and explain where her drink of choice is. 2 pillows under head for increased cervical support. Head support, padded arm rests and left lateral trunk supports in chair. EATING: Provide set up assist as desired by the resident prn. Inform resident where foods are on the plate utilizing clockmethod and provide physical assistance as requested. Resident #7 (R7) Review of a Face Sheet revealed R& was a [AGE] year old female, originally admitted to the facility on ,[DATE]//15, with pertinent [DIAGNOSES REDACTED]. Review of a BIMS revealed R7 had severe cognitive impairment. Review of an Occupational Therapy note dated 06/25/20, indicated that R7 has been total assist with self feeding secondary to hand contractures. During an observation on 07/23/20 at 10:18 A.M., R7 was in bed, resting with eyes closed. Water cup was on bedside table, out of reach of R7 and was noted to be 1/2 full. Staff entered and exited R7's room without offering any water. During an observation on 07/23/20 at 2:31 P.M., R7 was in bed, resting with eyes closed. Water cup was on bedside table, out of reach of R7 and was noted to still be half full. Staff entered and exited R7's room without offering any water. During an observation on 07/27/20 at 9:10 A.M., R7 was seated in the hallway with a table and a cup of water set in front of her. The 8 ounce cup of water was full and had a straw. Multiple observations were made between 9:10 A.M. and 11:00 A.M. of staff walking past R7 and not offering any fluids. Resident #8 (R8) Review of a Face Sheet revealed R8 was a [AGE] year old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a physician progress notes [REDACTED]. Review of a Nutrition assessment dated [DATE], revealed that R8 utilized a kennedy cup at bedside for water pass. During an observation on 07/23/20 at 10:41 A.M., R8 was up in the wheelchair, kennedy cup was on the bedside table, out of reach of R8, full of fluid, and the top part of the straw was covered with paper. During an observation on 07/23/20 at 2:40 P.M., R8 was in bed resting with eyes closed, kennedy cup was on the bedside table, out of reach of R8, full of fluid, and the top part of the straw was still covered with paper. This would indicate that R8 had not taken a drink from the cup of water since the morning water pass. During an observation on 07/27/20 at 9:15 A.M., R8 was sitting up in the wheelchair, kennedy cup on TV stand, out of reach, full of fluid, and the top part of the straw had the paper cover still on it. During an observation on 07/27/20 at 10:50 A.M. R8 was sitting up in the wheelchair, kennedy cup on the TV stand, out of reach, full of fluid and the top of the straw had the paper cover still on it. During an interview on 07/27/20 at 11:20 A.M., RN Y indicated that anytime an aid or nurse in in a resident's room, fluids should be offered. During an observation on 07/27/20 at 1:30 P.M., R8 was in bed resting with eyes closed, call light was clipped to the bedding just below R8's knee, kennedy cup on bedside table, full of liquid, and the straw still had the paper cover on. This would indicate that R8 had not taken a drink from the kennedy cup since the morning water pass. During an interview on 07/27/20 at 1:47 P.M., CNA X stated that the expectation was for staff to offer fluids to residents anytime staff are in the rooms.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake # MI000- 6. Based on observation, interview, and record review, the facility failed to follow current infection control practices and guidelines for residents on Maple and Birchwood halls, resulting in the potential for the spread of COVID 19 throughout the facility. Findings: During entry to the facility on [DATE] at 7:15 P.M., both front doors were unlocked and unattended. This surveyor entered the building unnoticed and was not stopped or asked by any staff if a COVID screening was completed before entry. During an observation on 07/20/20 at 7:20 P.M. Registered Nurse (RN) A stood at the nurses station without a mask on. During an observation on 07/20/20 at 7:21 P.M., Certified Nurse Aid (CNA) B walked through the hall with a mask pulled down below the nose and mouth. During an observation on 07/20/20 at 07:36 P.M. CNA F stood in room M04, talked with two female residents, and wore a mask that did not cover the nose and mouth, rather was rested on the chin. During an interview on 07/20/20 at 8:10 P.M., CNA C stated that all staff must wear a mask at all times while in the building. During an observation on 07/20/20 at 8:21 P.M., CNA F talked with three residents who were seated out in the hallway of Maple. The mask CNA F wore was positioned below the nose and mouth and rested on the chin. During an interview on 07/21/20 at 11:55 A.M., CNA K stated that the expectation was for all staff to wear a mask while inside the building. During an interview on 07/21/20 at 1:20 P.M., the administrator (ADM) indicated that at the present time, masks were to be worn by all staff at all times while in the building. During an observation on 07/23/20 at 1:35 P.M., while returning to the facility, this surveyor was screened by employee T. Employee T (1) did not perform hand hygiene before or after the screening process, (2) did not sanitize the thermometer before or after its use, and placed it into the tub on the table where it was stored, and (3) did not sanitize the ink pen before or after its use, and placed it into the tub on the table where it was stored. During an observation on 07/23/20 at 2:35 P.M., employee U was in the nourishment room filling cups of ice and water for 2nd shift water pass. Employee U's mask was looped around the right ear and hanging free, not covering the mouth or nose. During an interview on 07/23/20 at 2:42 P.M. employee 'U stated that the water cups were for Birchwood and that the expectation for staff was to be wearing a mask at all times. I know I should have had it on.