STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235333	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGENCY, A VILLA CENTER	12575 S TELEGRAPH RD TAYLOR, MI 48180

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 008. Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was complete and accurate for one resident (#702) reviewed for resident status, resulting in the potential for unidentified and unmet resident care needs. Findings include: A review of the clinical record for Resident #702 (R702) revealed an admission into the facility on [DATE] and discharge from the facility on 8/7/2020. Her [DIAGNOSES REDACTED]. An initial MDS dated [DATE] was completed on R702. On 8/26/2020 beginning at 11:13 AM, when MDS Coordinator, Staff D was queried about the purpose of MDS Section C (Cognitive Patterns), she said, It's for cognition to determine the resident's level. It they are confused or not. Staff D added the cognition information is important because it can affect the way they are taken care of. They may need more care than someone else. A review of R702's MDS assessment, dated 7/16/2020, was conducted with Staff D and revealed Section C (Cognitive Patterns) was noted not assessed for each question. Staff D said, (Not assessed) indicated it wasn't completed in a timely fashion. Staff D identified MDS Nurse, Staff E as the person responsible for completing Section C. When a policy governing the completion of the MDS was requested, Staff E stated the RAI (Resident Assessment Instrument) manual provided guidance on completion of the MDS. On 8/26/2020 at 11:17 AM, when Staff E was queried about why she was unable to complete Section C of R702's MDS assessment in a timely fashion, she said, I didn't get to the interview on time. It just didn't get done. On 8/26/2020 at 1:04 PM, when the Director of Nursing was queried about her expectations for MDS completion, she said, I expect them to get it done in a timely manner. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) Manual dated October 2019 documented, The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident.
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 pertains to intake MI 008. Based on interview and record review, the facility failed to initiate individualized and comprehensive care plans for areas of concern identified on an initial Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) for one resident (#702) reviewed for care plans, resulting in potential barriers for the resident to achieve their highest practicable physical, mental, and psychosocial well-being. Findings include: A review of the clinical record for Resident #702 (R702) revealed an admission into the facility on [DATE] and discharge from the facility on 8/7/2020. R702's [DIAGNOSES REDACTED]. An initial RAI/MDS dated [DATE] was completed on R702. On 8/26/2020 beginning at 11:13 AM, when MDS Coordinator, Staff D was queried about the Care Area Assessment (CAA) of the Resident Assessment Instrument (RAI), she said, It's something that stands out on the patient; an actual or potential problem. When Staff D was queried if comprehensive care plans are generated from the CAAs, she said, Yes. When staff D was queried about who was responsible for developing resident's comprehensive care plans, she said, It could be anyone who completed the MDS such as a nurse, Registered Dietitian, Social Worker, or Activity Director. Staff D added, Comprehensive care plans should be developed 21 days after admission. When a review of the CAA section of R702's RAI dated 7/16/2020 was conducted with Staff D, the following problem-oriented care areas were identified: dehydration, pressure ulcer, [MEDICAL CONDITION] drug use, falls, communication, and urinary incontinence. When Staff D was queried if a comprehensive care plan should have been developed for all these problem-oriented care areas, she said, Yes. A review of R702's current care plans was conducted with Staff D. When Staff D was queried if a comprehensive care plan had been developed for dehydration, pressure ulcer, [MEDICAL CONDITION] drug use, falls, communication, or urinary incontinence, she said, No. I don't see one. When Staff D was queried about who was responsible for developing comprehensive care plans for dehydration, pressure ulcer, [MEDICAL CONDITION] drug use, falls, communication, and urinary incontinence, she stated the nurse, but the social worker could have done the [MEDICAL CONDITION] drug use too. Staff D identified MDS Nurse, Staff E as the nurse responsible for completing the comprehensive care plans for R702. On 8/26/2020 at 11:17 AM, when Staff E was queried about why R702's comprehensive care plans had not been developed, she said, I have no answer. On 8/26/2020 at 1:04 PM, when the Director of Nursing was queried about her expectations for comprehensive care plan development, she said, That the MDS Coordinator and nurse on the floor work together to complete them within 21 days. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) Manual dated October 2019 documented the following: In accordance with 42 CFR 483.21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
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** This citation pertains to intake MI 007 Based on Observation, Interview, and Record Review, the facility failed to accurately assess, and document a resident's skin integrity, and update interventions to prevent the development and worsening of pressure ulcers for 1 resident (703) out of 3 residents reviewed for pressure ulcers. Findings include: A summary of an allegation submitted to the state of Michigan provided concerns related to the treatment of [REDACTED]. On 8/25/20 at 11:04 am the surveyor approached Nurse (O) and requested an observation of the dressing change for resident 703. Nurse (O) stated, sure, you are lucky the resident is back from [MEDICAL TREATMENT]. I figured you would be looking at the resident's abdominal wound, he no longer has a wound vac. and the wound looks a lot better than it did. Nurse (O) was asked if that was the resident's only wound, and she stated no he has some dried up scabs on his heels that are vascular and only require dry dressing changes at this point, the wound scabs were removed by the wound care team. After the completion of the upper abdominal dressing change, and the application of dry dressings to the resident's feet, the surveyor left the resident's room. Approximately 5 minutes later the surveyor returned to the room of resident 703 and observed Nurse (O) receiving assistance with turning resident 703 from his back to his side. The surveyor observed nurse (O) applying a dressing to the sacrum of resident 703. The dressing was dated 8/25/20 and included nurse O's initials. When Nurse (O) left the room, the surveyor asked her why a dressing was covering the resident's sacrum, Nurse (O) stated, that area is just a little inflamed, it is mostly cicatrix (skin scaring from old wounds). Now it has gotten worse, and I will have to let my boss know. On 8/25/20 at 3PM a review of the clinical record revealed resident 703 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident goes out of the facility for [MEDICAL TREATMENT] 3 times a week. The resident's admission MDS (minimum data set) dated 8/5/20 revealed a BIMS (brief interview of mental status) score of 3/15, indicating a severe cognitive (thought processes) impairment. Resident 703 is non-ambulatory (cannot walk) and requires the use of a mechanical lift; supported by 2 staff, when removed from the bed. Resident 703 requires extensive one-person assistance with bathing. The resident has a urinary catheter in his bladder and is consistently incontinent (cannot control) of stool. Resident 703 has no use of his arms and requires extensive assistance 1-person assistance with bed-mobility. On 8/26/20 at

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) 9:15AM, the surveyor approached nurse (O) and asked if the dressings were already changed on resident 703. Nurse (O) stated, yes I just changed them. Nurse (O) was asked if the surveyor could just look at the resident's sacral area. Nurse (O) stated, yes I can just lift the dressing open. The surveyor looked at the sacral area and noted a moderately sized sacral pressure ulcer, with eschar, pale pink tissue, slough, and an undetermined depth. Nurse (O) stated, when the sacral area was first observed it was fragile skin however as of yesterday evening it was noted to have areas of pressure breakdown. I called the residents doctor for wound treatment orders. I also let the resident's daughter know about the pressure ulcer. The surveyor requested any available documentation specific to the sacral pressure ulcer. Nurse (O) stated you will have to obtain that information from my boss. When asked if she was referring to the Director of Wound Care, Nurse (O) stated, yes. An interview was conducted with Nurse (N) on 8/26/20 at 9:45am regarding the sacral pressure ulcer of resident (703). Nurse (N) stated, I was told you needed some documentation related to the sacral pressure ulcer for resident (703), I don't understand what it is you want because there is only one document. Nurse (N), stated I was made aware of the sacral pressure ulcer yesterday by the wound nurse, and I was present when she notified the family. Nurse (N) requested to view the surveyor's computer to locate the skin assessments for resident (703). Nurse (N) located the most recent skin assessment for resident 703 dated 8/17/20. There were no identified skin conditions noted in the sacral area of the skin assessment diagram. Nurse (N), looked at the diagram again and stated, I did not think the resident's sacral pressure ulcer occurred over night. A record review of a nursing progress note entitled; skin/wound note dated 8/25/20 at 17:55 was conducted on 8/26/20. The progress note indicated nurse (O) spoke with a family member of resident (703) to inform them of a new facility acquired wound to bilateral buttock/coccyx. Nurse (O) reviewed the planned treatments with the family member of Resident (703). According to the progress note the family member stated she was aware this might happen because the resident is not able to move freely. An interview was conducted with the DON on 8/26/20, the DON stated she was aware of the pressure ulcer situation and would provide the surveyor with the facility policy and procedure that addresses skin management. A document entitled, Villa (skin management guideline) with an effective date of 11-28-17, identified its purpose as ensuring residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce, and treat skin breakdown. Guidelines for the prevention of Pressure Ulcers consists of: (1) All residents admitted to the facility will be evaluated for actual and potential skin integrity issues. (2) The Admission Evaluation will be completed upon admission. (3) The skin and body check section should be completed within the first 2 hours. (3) The Pressure Injury Notice will be completed and provided for the resident and/or Resident Representative providing notice of predicting factors and baseline care plan interventions to support prevention treatment and healing. Under the section of the document entitled, Monitoring of Skin Integrity the skin should be: (1) Observed daily during care by the nursing assistants. If any skin concerns are noted they are to be reported to the licensed nurses. (2) Weekly skin observations on the bath/shower day will be performed by a Licensed Nurse. (3) If a skin concern is noted, refer to the skin and wound care formulary (4) The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. (5) The Physician will be consulted with changes suggesting impairment in skin integrity
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 823 Based on observation, interview and record review, the facility failed to follow therapy recommendations to initiate restorative services to maintain strength, range of motion, and mobility for one resident (#711) of 3 residents reviewed for the provision of specialized rehabilitative services, resulting in the potential for a decline in physical strength, range of motion, and mobility. Findings include: A summary of an allegation submitted to the state of Michigan provided concerns related to the lack of therapy services provided to resident (711), in addition to a general lack of mobility for the resident. An interview of resident (711) was conducted on 8/25/20 at 12:11 pm, the resident was quired about life in the facility while lying in the bed. The resident stated, I have not been to therapy since I came here, I had my right hip replaced in the past. My sister told me how to exercise when I am lying in the bed. Resident demonstrated upper arm ROM exercises. The resident stated, the physical therapist informed me my insurance has not kicked in yet. In the other place they use to get me in the wheelchair and take me to therapy, but they do not here. I am always lying in bed here. A review of the medical record of resident (711), revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A record review of the resident's quarterly MDS (minimum data set) dated 6/21/20 revealed a BIMS (brief interview of mental status) of 14/15 indicating resident (711) is cognitively (thought process) intact. The resident required total one-person assistance with transfers, and extensive one-person assistance with dressing, hygiene, and eating. Resident (711) has one-sided limitation in the range of motion of her lower limbs. An interview was conducted with P in the Therapy Department on 8/26/20 at 9:23am. An inquiry was made regarding the physical therapy evaluation for Resident (711). After reviewing documents, P stated, the resident was evaluated for therapy services in March , and a physical therapy assessment was conducted. She did not qualify for therapy due to insurance issues. The resident's insurance was denied for physical therapy. Resident (711) was discharged to restorative nursing program. P provided the surveyor with a document entitled, PT Evaluation & Plan of Treatment. The last page of the document included orders for restorative nursing dated 7/6/20. The orders for restorative included: AAAROM bilateral lower extremities 3x10 Bring Legs side to side up and down toward chest and ankle pumps 2 x weekly. An interview was conducted with the assistant DON (F) on 8/26/20 at 11:00 am. (F) stated, there is no formal restorative nursing program at the facility. There are 2 CNA's in the facility that provide Restorative Nursing in the facility. The resident's restorative notes may be in hard copy and not in the Electronic Medical Record, I will check. An additional interview was conducted with the assistant DON (F) on 8/26/20 at 3:39PM. Assistant DON (F) provided the surveyor with a document that indicated Range of Motion activities should be performed via the CNA during ADL care. A search in the EMR (Electronic Medical Record) was conducted via the surveyor with DON (F) in attendance to locate the completion and documentation of the task in the EMR. There was no documentation specific to Range of Motion as an assigned task via CNA's for resident (711) in the EMR. The Don stated to the surveyor, there is no restorative nursing program and there is no policy to ensure that a resident that could benefit from ROM exercises receives it, and that it is documented.
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 has two deficient practices. Deficient practice #1. This citation pertains to intake numbers MI 747, MI 926, and MI 008. Based on observation, interview and record review the facility failed to ensure timely provision of weight loss interventions for three sampled resident (R#'s 702, 708, and 709) from a total sample of 17 resulting in the potential for further weight loss and compromised health condition. Findings include: R709 A complaint called into the State Agency documented, It was alleged the facility staff failed to assist the resident with feeding. On 8/25/20 at 10:20 AM, R709 was observed sitting up in his wheelchair in his room. Two half drunk bottles of pop were noted on the bedside table. On 8/26/20 at 8:15 AM, R709 was observed feeding himself a bowl of cereal saying, My mouth is sore. Record review revealed that R709 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set Assessment ((MDS) dated [DATE] documented the resident cognition was moderately impaired and required one person assistance with feeding. Review of the current weights revealed that R709 had an admission weight of 177.0 Lbs on 6/5/2020 and on 8/1/2020 weighed 142.2 Lbs (a difference of -34.8 lbs loss in 8 weeks). The current physician orders [REDACTED]. A nutritional assessment dated [DATE] documented NO RICE; double portions with breakfast for nutrition. Monitor po (by mouth) intake, weight and labs. The 6/7/20 care plan titled, The resident has nutritional problem or potential nutritional problem related to limited adherence to nutrition-related recommendations, Diet restrictions=Carb controlled had an intervention of Evaluate any weight changes. Determine percentage changed and follow facility protocol for weight change .Resident is blind, and needs assistance and cues with eating. At 10:36 AM, Dietician C was interviewed and asked about R709's weight loss and stated, That is a 75% weight loss in 2 months, that's pretty severe. I don't know why it wasn't brought to my attention in morning meeting. I review the weights monthly and didn't see that. Dietician C indicated no additional nutritional assessment or supplements were implemented because I was not aware of the weight loss, no one brought it to my attention. On 8/26/20 at 3:15 PM, during an interview with the facility's Director of Nursing (DON) she said that she was

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F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) aware of the concern regarding the resident's weight loss and nutritional supplements were ordered. Review of the facility provided Clinical Nutrition Guidelines documented, .Refer residents with significant weight loss, skin breakdown, or those on tube feeding or [MEDICAL TREATMENT] to the dietitian for further nutritional assessment .The resident is weighed on admission or readmission Admission weight may be compared to the resident's usual body weight if the usual body weight is known. New admissions may be weighted weekly for the first four weeks .Significant weight change is defined as 5% in one month, 7.5% in three months, and 10% in six months .Once a significant weight change has been identified, the director of nursing or person in charge notifies the physician, dietitian, diet technician, and the director of food and nutrition services .Interventions are provided to address a decline in a resident's appetite and food intake, a significant weight loss or an insidious weight loss trend. Resident #702- A review of the clinical record for Resident #702 (R702) revealed an admission into the facility on [DATE] and discharge from the facility on 8/7/2020. R702's [DIAGNOSES REDACTED]. A MDS dated [DATE] documented R702 required extensive one-person physical assistance for eating. On 8/26/2020 at 8:46 AM, when Dietary Director, Staff B was queried about the facility's weight monitoring policy, she said, Residents are weighed upon admission and then weekly for four weeks; and, if stable, they go monthly. Staff B added, this schedule is maintained to make sure the residents are meeting their nutritional needs, maintaining their weights, and to establish a baseline. On 8/26/2020 at 9:09 AM, when Registered Dietitian, (RD) C was queried about the facility's weight monitoring policy, she said, There is an initial weight (obtained) on new admissions and then redone weekly for four weeks. RD C added, For example if the weight was done on a Monday, it should be redone the next Monday. It's a set day. It's better for us to stay on a set day because then it's put in the computer to specify. It's a trigger for the nurses to ensure that it's done. A review of R702's clinical record was completed with RD C. During this review, it was confirmed that R702 was a resident in the facility from 7/7/2020 to 8/7/2020. During her stay, the facility obtained only one weight on R702 dated 8/1/2020. When RD C was queried about the lack of weights obtained on R702, she said, It's horrible that her first weight was done on 8/1/2020. Resident #708- A review of the clinical record for Resident #708 (R708) revealed an admission into the facility on [DATE] and discharge from the facility on 4/22/2020. R708's [DIAGNOSES REDACTED]. A MDS dated [DATE] documented intact cognition, and R708 required only supervision for eating. A comprehensive nutrition assessment dated [DATE] documented resident has many food allergies [REDACTED]. The only weights obtained on R708 were 140# on 4/13/2020 and 139.2# on 4/14/2020. On 8/26/2020 at 12:56 PM, when the Director of Nursing was queried about her expectations for weighing residents in the facility, she said, Residents are weighed upon admission; weekly times four weeks; and reviewed after that to determine what we need to do. The facility document titled, Weight Monitoring, undated, was reviewed and revealed in part the following: -Guideline: To ensure the resident maintains acceptable parameters of nutritional status unless their clinical condition demonstrates that this is not possible, the resident's body weight is monitored. -Procedure: The resident is weighed on admission or readmission. New admissions may be weighted weekly for the first four weeks. Residents are weighed monthly. The monthly weight is compared to the previous weights to determine significant and insidious weight changes. Resident with a 5% weight change in one month are re-weighed. Finalized weights are entered into the computer on a predetermined date, the 7th of the month. Significant weight change is defined as 5% in one month, 7.5% in three months, and 10% in six months. Once a significant weight change has been identified, the director of nursing or person in charge notifies the physician, dietitian, diet technician, and the director of food and nutrition services. Deficient practice #2. This citation pertains to MI 481. Based on interview and record review, the facility failed to provide a follow-up nutritional evaluation for one resident (#710) reviewed for a tube feeding and determined to be at nutrition risk, resulting in the potential for nutrition concerns to go undetected. Findings include: It was reported to the state agency that the facility was not appropriately monitoring resident's tube feeding. A review of the clinical record for Resident #710 (R710) revealed an admission into the facility on [DATE] and discharge from the facility on 8/7/2020. R710's [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented moderate cognitive impairment. A review of physician orders [REDACTED]. On 8/26/2020 at 10:02 AM, an interview was conducted with Registered Dietitian, (RD) C. When RD C was queried if R710 was a resident considered at nutrition risk, she said, Yes because of COVID-19, [MEDICAL CONDITION], diabetes mellitus, obesity, and dysphagia. A review of a nutrition note dated 6/19/2020 was conducted with RD C and the following was documented: Nutrition at risk meeting held on 6/17/2020. Resident consumes carb controlled, mechanical soft, thin liquids diet. Weight loss 5%: 4/20 265# to 6/20 243#. Recently in past resident was diagnosed with [REDACTED]. Nurse Practitioner asked if we could decrease tube feeding in hopes of increasing by mouth intake. Food Acceptance Record 51-100%. Will continue to monitor for next decrease in tube feeding with maintenance of weight. Will follow with interdisciplinary team. A review of a nursing note dated 7/22/2020 was conducted with RD C and the following was documented: New orders received to discontinue tube feeding related to weight gain with decrease in amount. Weights to be done weekly to monitor weight. Resident to continue to receive flushes via peg (Percutaneous Endoscopic Gastrostomy tube). When RD C was queried if there was monitoring and follow up by the dietitian as stipulated in the nutrition note of 6/19/2020, she said, It's not there. There should be some follow up. When RD C was queried about the justification for the discontinuation of R710's tube feeding, she said, If there is a decrease in tube feeding, we should know about it. It should be discussed in morning meeting. This resident would be one of the first people we see. If we are decreasing tube feeding, I should go see them. We should have been notified in morning meeting and she would have been one of the first people I saw. I should have gone and put a note in (the clinical record). There has to be a failure to communicate. I should have been notified. There should be a note from me saying I saw the patient and completed a full assessment. There should have been an assessment by the RD. Because she was at risk, there should have been a note from the RD in July. On 8/26/2020 at 12:56 PM, the discontinuation of R710's tube feeding was discussed with the Director of Nursing (DON). When the DON was queried if the dietitian should have completed an evaluation on R710 regarding the discontinuation of the tube feeding, the DON said, Yes. A review of the following facility documents revealed in-part the following: -Registered Dietitian Job Description: Timely completion of the Medical Nutrition Therapy is required in accordance with company policy and current standards of practice. Assesses nutritional needs of residents and patients. -Registered Dietitian Roles & Responsibilities: Assess the nutrition needs of residents who are deemed both high risk and low risk. The effectiveness of the nutrition interventions is re-evaluated as needed to determine if they continue to be appropriate -Dietary Recommendations: Upon assessing a resident's nutritional status the dietitian and/or diet technician may make a recommendation to change the diet order. -Enteral Tube Feeding: The dietitian may recommend changing the tube feeding if necessary. The dietitian will monitor the nutritional status of the tube-fed residents on a monthly basis or more frequently if indicated. -Tube Feeding Advancement: The dietitian will monitor the tube feeding and the oral feeding to determine the best combination to meet the resident's nutritional needs.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 260. Based on interview and record review the facility failed to ensure timely pain management for one sampled resident (R707) from a total sample of 17 resulting in unmanaged pain. Findings include: A complaint called into the State Agency documented, It was alleged the facility failed to assess and timely treat the resident (R707) for foot pain. Record review on 8/25/20 at 10:43 AM, revealed that R707 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set Assessment ((MDS) dated [DATE] documented the residents cognition was intact and required staff assistance with moving from seated to standing position. Review of the progress notes documented: -6/11/20 Physical Medicine and Rehabilitation Physicians Assistant note, Pain is controlled on current regimen. -6/12/2020 (the next day) Social Service Note: Resident informed writer that she would like to d/c (discharge) from the facility as soon as possible. Resident has also informed writer that resident has constant pain in her feet, and resident is unable to stand effectively. Writer contacted resident's emergency contact regarding a possible d/c to home . There was no documented evidence that the Social Worker notified any medical staff member that R707 was having constant pain in her feet. -6/19/2020 Care Management note: An Ongoing or Discharge Care Management meeting was held. The resident's plan for living arrangements have not changed. There are functional barriers to the resident's discharge plan which include: Transfers; Walking . -6/23/2020 Nurses Note: Resident wishing to do PT (physical therapy) however, pain in the sole of both feet inhibited(s) her participation at past Sessions. (name of attending physician) writing new order for medication for pain so she may complete her PT. -6/23/20 Physical Medicine and Rehabilitation Physicians Assistant note, Pain is controlled on current regimen and right next to it was a contradicting hand written note documenting, complains of bilateral feet [MEDICAL CONDITION] (weakness, numbness and pain from nerve damage). Order [MEDICATION NAME] (medication for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) the treatment of [REDACTED]. 11 days after the resident reported having constant pain in her feet. Review of the Medication Administration Records (MAR's) dated June 2020 indicated the R707 had Tylenol 325 mg two (2) tablets every 6 hours as needed for mild pain. Upon review the Tylenol was not given on 6/12/20 (the day R707 complained of constant pain in her feet). Review of the June 2020 MAR's from 6/12/20 until 6/23/20 (the time frame which R707 complained of foot pain) revealed the the resident received Tylenol 4 times in the 11 day time span. 8/26/20 at 11:53 PM, during an interview with the Inservice Nurse (Nurse F) she was asked about the note from Social Worker dated 6/12/20 where the resident informed the facility staff of constant pain in foot and asked who she reported that information to. Nurse F said, I don't know what social worker did with that information. The social worker should have told someone in nursing. Review of the facility's policy titled, Pain Management dated 11/28/17 documented, .The residents experience of pain is highly individual and subjective. Pain is what the resident says it is .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 214. Based on observation, interview and record review the facility failed to implement appropriate infection control measures for one sampled resident (R717) from a total sample of 17, resulting in the potential for the spread of infection during a pandemic. Findings include: On 8/25/20 at 12:55 PM, observation was made of Physical Therapist L assisting R717 up and down the stairway adjacent to the second floor nursing unit. R717 was holding onto the handrails while going up and while going down the steps. Upon completing the step work therapist L and R717 entered through the door which lead to the second floor nursing unit. No disinfecting was done on the stairway handrails. Two staff members were observed passing through the potentially contaminated stairway area. Noted on the door was signage which read, STOP. This is a COVID + (positive) Unit. Do not enter unless you have the appropriate PPE (personal protective equipment-face shield, N95 mask, gown) and have been assigned to this unit! Staff must keep mask on at all times. Observation on the unit revealed one maintenance staff member H and Certified Nurse Assistant (CNA I) both not wearing a mask. Upon questioning the staff as to why no mask Staff H stated, I don't know why. I guess I just wasn't thinking. CNA I stated, I was just taking a break from my mask. Record review revealed that R717 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The admission nursing assessment dated [DATE] indicated the resident cognition was intact. At 1:15 PM, the Infection Control Nurse (Nurse M) was interviewed regarding the observations. Nurse M said that the resident residing on the second floor nursing unit were potential COVID positive, untested residents or residents that tested negative at the hospital and were on a 14 day quarantine. Nurse M said that staff are to be wearing masks at all times and the stairway handrails should have been disinfected with (name of bleach solution) after patient therapy. At 2:43 PM, during an interview with the facility's Administrator she stated the one to one inservices were being given to staff regarding proper infection control practices. Review of the facility's policy titled Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) with an Effective Date: 3.26.2020; Revised: 4.6.2020 documented, . For the duration of the state emergency all Long Term Care facility personnel should wear a facemask while they are in the facility . The facility's Environmental Cleaning and Disinfection COVID-19 policy dated 3/19/20 documented, All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected between patient use utilizing beach and water mixed solution or a disinfectant the is EPA registered appropriate for [DIAGNOSES REDACTED]-CoV-2.