STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235020	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MICHIGAN MASONIC HOME	1200 WRIGHT AVE ALMA, MI 48801

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 0689 **Level of harm -** Minimal harm or potential for 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 intakes 5, 5 and 9 and contains 2 deficient practice statements. A) Based on observation, interview and record review, the facility failed to ensure staff were familiar with a mechanical lift and specialized wheelchair for one resident (Resident #11) of 16 residents reviewed, resulting in the potential for a fall and/or accident hazard from incorrect use or improperly fitted specialized wheelchair. Findings include: Review of the facility Lift Policy last revised 10/12/2018 reflected It is the policy of (facility) to reduce and/or prevent staff injury during lifting and transferring residents. The policy indicated Residents who are non-weight bearing shall be transferred with a mechanical lift unless the evaluation indicates use of the lift would be contraindicated i.e. residents with an unstable fracture, casts that are unable to be accommodated with the mechanical lift slings, and/or unpredictable behaviors. The policy was silent on the number of staff required to operate a mechanical lift but did specify Residents who are capable of bearing weight during transfers but exhibit behaviors that make the transfer process unpredictable (i.e. Combativeness) shall be transferred with a minimum of 2 people. The policy also mentioned, All direct care staff will be trained in the use of the mechanical lifts and 2 person transfers during the new employee orientation process and as part of the ongoing employee in-service process as needed. Resident #11 Review of a facility Admission Record dated [DATE] reflected Resident #11 was a resident of the facility with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #11 needed extensive assistance from one person for bed mobility, dressing and eating and was totally dependent on one person for transfers, personal hygiene and bathing. The MDS assessment also indicated Resident #11 was independent with decision making and had functional limitations in range of motion of both upper and lower extremities. Review of a Care Plan dated [DATE] reflected Resident #11 was At risk for falls and displays mobility deficits related to [MEDICAL CONDITIONS], CAD ([MEDICAL CONDITION]), Type 2 DM (diabetes mellitus),[MEDICAL CONDITION](high blood pressure), [MEDICAL CONDITIONS], vitamin Deficiency, absence of left toe, Constipation, [MEDICAL CONDITION] and chronic pain, [MEDICAL CONDITIONS]. Exhibits: potential medication SE's (side effects), requires staff assistance for transfers and toileting, non-ambulatory, ROM (Range of Motion) deficits to BLE (bilateral lower extremities) related to contractures to ankles, chronic pain, (Resident #11) has been noted to grab onto the bar on the wall during transfers, (Resident #11) holds on to the top of the lift at times during transfers, mobility/ADL (Activities for Daily Living) tasks fluctuate from ext (extensive) to dependent likely related to mood, muscle weakness and fatigue, (Resident #11) prefers bed at a higher level against safety education. A goal of the Care Plan was (Resident #11) will maintain the ability to assist with repositioning in bed with the use of bilateral enabler bars and transfer with the full hoyer lift on daily basis over the next quarter in order to maintain mobility status and reduce risk for falls with injuries. Interventions on the Care Plan to meet the goal included (Resident #11) to use the high back WC (wheelchair) or MMR for appointment transportation and Hoyer lift dependent assist x 1 (one staff person); tan hoyer sling. (Resident #11) uses EZ-lift Tan with tabs. During an observation on [DATE] beginning at 11:30 AM, Certified Nurse Aide (CNA) Q and CNA EE provided personal care to Resident #11 who needed to be ready for an outside appointment by 12:00 PM. CNA Q said she knew Resident #11 needed to be transferred to a special chair for transportation to the appointment but didn't know what kind of chair it was. CNA EE said she was not normally assigned to the hall where Resident #11 lived and wasn't familiar with his plan of care. CNA Q and CNA EE positioned Resident #11 onto a rectangular, tan colored sling that did not include bifurcated leg sections. Both CNA Q and CNA EE said they had not been trained on the use of the EZ-Lift machine and admitted they were unfamiliar with how to attach the sling to the lift and transfer Resident #11 to the specialty chair. Resident #11 was overheard crying out in pain and yelling at CNA Q and CNA EE about the positioning of the loops on the straps that would attach to the lift. Resident #11 was also overheard telling staff to place hand towels under each of his knees to protect against friction and pressure. Registered Nurse (RN) DD entered the room in an attempt to assist with the transfer and also struggled with understanding Resident #11's directions. Resident #11 repeatedly said They've got the wrong strap on! Black goes on this side, green goes on the television side! Resident #11 was trying to convince staff to utilize the black strap at the top of the sling, and the green loops on the lower part of the sling. This would allow for Resident #11 to be in an upright position while being lifted off the bed and into the chair. RN DD, CNA Q and CNA EE were observed struggling to position Resident #11 in the lift over the specialty chair, all the while Resident #11 was overheard yelling Ow! Ow! Ow!. Once Resident #11 was placed into the specialty chair, Resident #11 needed a headrest and the footrests applied. CNA Q, CNA EE and RN DD were not familiar with which headrest Resident #11 needed in the wheelchair and were not familiar with how to fasten the headrest to the chair. At 12:20 PM, Resident #11 was overheard saying Great, I'm going to miss another appointment! Occupational Therapist (OT) J was summoned to the room and was able to identify the wrong headrest had been attempted, directed staff to get a headrest from Resident #11's electric wheelchair, and was unable to locate tools stored on the chair for staff to secure the headrest. OT J was overheard telling CNA Q and CNA EE that she had stored allen wrenches in a pouch on the cushion of Resident #11's motorized wheelchair for use in securing the headrest. Both CNA Q and CNA EE said they were unaware they were expected to know how to use tools to modify the specialized wheelchair. During an interview on [DATE] at 2:15 PM, CNA EE reported she had never been trained on the use of the EZ-lift machine used in Resident #11's room. CNA EE said she was not familiar with the specialized chair used by Resident #11 when going to outside appointments and did not know how to secure the headrest or the footrests. CNA EE admitted that she didn't know which loops to use for appropriate lifting of Resident #11 and said the loops initially chosen seemed too loose. CNA EE said she would ask a nurse or a CNA familiar with Resident #11's plan of care how to care for residents she was unfamiliar with. CNA EE said she had no idea staff other than therapy staff were expected to use tools to make modifications to a specialty chair. CNA EE said she wasn't sure what the facility policy was related to number of staff needed to complete a lift or transfer using a full lift machine, but was aware it depended on the resident whether or not more than one staff were needed to complete a full lift transfer, possibly based on weight or upper body strength. CNA EE did not reference utilizing the resident Care Guide/Kardex until prompted to do so, instead reporting that any pertinent care needs were communicated in shift change report or on a Chart Sheet (paper guide used by CNA's to make notes about resident care). During an interview on [DATE] at 4:00 PM, CNA Q reported she had only cared for Resident #11 once and explained she took the lead with operating the EZ-lift because she had seen it done before but admitted she had never been trained on the EZ-lift device used by Resident #11. CNA Q said she was confused about which loops to use to attach the sling to the EZ-lift. CNA Q said specialty chairs are NOT specified on the Care Guide used by nurse aides and admitted she was unfamiliar with the specialty chair used by Resident #11, its headrest and foot pedals. CNA Q said she was never told tools were available to modify specialty chairs. CNA Q did not reference utilizing the resident Care Guide/Kardex until prompted to do so, instead reporting that any

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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MICHIGAN MASONIC HOME	1200 WRIGHT AVE ALMA, MI 48801

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) pertinent care needs were communicated in shift change report or on a Chart Sheet (paper guide used by CNA's to make notes about resident care). During an interview on [DATE] at 1:02 PM, OT J reported she had fitted Resident #11 in a tilt in space chair (the specialty chair observed on [DATE]) in September 2019. OT J said Resident #11 needed to use the headrest from his motorized wheelchair because it was longer and obtained allen wrenches to keep in a pouch attached to the cushion on his motorized wheelchair. OT J said she only trained two CNA's to use the tools to make the needed changes to Resident #11's chair and did not include specific instructions for other staff who may be less familiar with Resident #11 in case one of the other aides or she were not available to assist in the transfer. This citation pertains to intake 5 (B) Based on interview, and record review, the facility failed to properly supervise and/or monitor one Resident (#2) out of six Residents reviewed for supervision. This deficient practice resulting in a resident to resident incident and potential for injuries. Findings include: According to the Minimum Data Set (MDS) assessment, dated 1/22/2020, Resident #2 had multiple [DIAGNOSES REDACTED].#2 required extensive assistance of staff for moving in bed, transferring, and dressing. Resident #2 was independently able to walk in room and on the unit. Staff assessed Resident #2 as moderately cognitively impaired. Resident #2 had a responsible party that made health care and financial decisions. According to an incident report dated 2/10/2020, at approximately 8:10 PM Resident #2 entered another resident's room. This Co-Resident reported Resident #2 had slapped her on the back. Review of facility investigation and signed employee written statements, no date, revealed no staff had been aware that Resident #2 had entered another resident's room. Review of Resident #2's progress notes dated 1/27/2020 indicated that Resident #2 becomes short tempered and easily annoyed and Resident #2 had 13 behaviors including kicking/hitting, pinching/scratching/spitting, and threatening behavior in the review look back period. Another progress note dated 1/7/2020 read, Resident is ambulatory and requires supervision out of her room. A Fall care plan intervention, initiated 7/22/2020, indicated that staff were to supervise Resident #2 when in the corridor and off the unit. During an interview on [DATE] at 12:15 PM, Registered Nurse G stated that she recalled the incident and was the nurse working with Resident #2 when the incident on 2/10/2020 occurred. RN G stated that no staff seen Resident #2 enter another resident room and that RN G was only aware of the incident as she had heard a resident yell out.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 5 and 9 Based on observation, interview and record review, the facility failed to ensure staff were able to demonstrate competency with staff assisted transfers, the use of specialty mobility devices and secure transportation in a personal vehicle for 2 residents (Resident #10 and Resident #11) of 16 residents reviewed, resulting in the potential for falls, accident hazards or serious injury during transfers or transport. Findings include: Review of the facility Lift Policy last revised 10/12/2018 reflected It is the policy of (facility) to reduce and/or prevent staff injury during lifting and transferring residents. The policy specified, All direct care staff will be trained in the use of the mechanical lifts and 2 person transfers during the new employee orientation process and as part of the ongoing employee in-service process as needed. Resident #11 Review of a facility Admission Record dated [DATE] reflected Resident #11 was a resident of the facility with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #11 needed extensive assistance from one person for bed mobility, dressing and eating and was totally dependent on one person for transfers, personal hygiene and bathing. The MDS assessment also indicated Resident #11 was independent with decision making and had functional limitations in range of motion of both upper and lower extremities. Review of a Care Plan dated [DATE] reflected Resident #11 was At risk for falls and displays mobility deficits related to [MEDICAL CONDITIONS], CAD ([MEDICAL CONDITION]), Type 2 DM (diabetes mellitus),[MEDICAL CONDITION](high blood pressure), [MEDICAL CONDITIONS], vitamin Deficiency, absence of left toe, Constipation, [MEDICAL CONDITION] and chronic pain, [MEDICAL CONDITIONS]. Exhibits: potential medication SE's (side effects), requires staff assistance for transfers and toileting, non-ambulatory, ROM (Range of Motion) deficits to BLE (bilateral lower extremities) related to contractures to ankles, chronic pain, (Resident #11) has been noted to grab onto the bar on the wall during transfers, (Resident #11) holds on to the top of the lift at times during transfers, mobility/ADL (Activities for Daily Living) tasks fluctuate from ext (extensive) to dependent likely related to mood, muscle weakness and fatigue, (Resident #11) prefers bed at a higher level against safety education. A goal of the Care Plan was (Resident #11) will maintain the ability to assist with repositioning in bed with the use of bilateral enabler bars and transfer with the full hoyer lift on daily basis over the next quarter in order to maintain mobility status and reduce risk for falls with injuries. Interventions on the Care Plan to meet the goal included (Resident #11) to use the high back WC (wheelchair) or MMR for appointment transportation and Hoyer lift dependent assist x 1 (one staff person); tan hoyer sling. (Resident #11) uses EZ-lift Tan with tabs. During an observation on [DATE] beginning at 11:30 AM, Certified Nurse Aide (CNA) Q and CNA EE provided personal care to Resident #11 who needed to be ready for an outside appointment by 12:00 PM. CNA Q said she knew Resident #11 needed to be transferred to a special chair for transportation to the appointment but didn't know what kind of chair it was. 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Black goes on this side, green goes on the television side! Resident #11 was trying to convince staff to utilize the black strap at the top of the sling, and the green loops on the lower part of the sling. This would allow for Resident #11 to be in an upright position while being lifted off the bed and into the chair. RN DD, CNA Q and CNA EE were observed struggling to position Resident #11 in the lift over the specialty chair, all the while Resident #11 was overheard yelling Ow! Ow! Ow!. Once Resident #11 was placed into the specialty chair, Resident #11 needed a headrest and the footrests applied. CNA Q, CNA EE and RN DD were not familiar with which headrest Resident #11 needed in the wheelchair and were not familiar with how to fasten the headrest to the chair. At 12:20 PM, Resident #11 was overheard saying Great, I'm going to miss another appointment! Occupational Therapist (OT) J was summoned to the room and was able to identify the wrong headrest had been attempted, directed staff to get a headrest from Resident #11's electric wheelchair and was unable to locate tools stored on the chair for staff to secure the headrest. OT J was overheard telling CNA Q and CNA EE that she had stored allen wrenches in a pouch on the cushion of Resident #11's motorized wheelchair for use in securing the headrest. Both CNA Q and CNA EE said they were unaware they were expected to know how to use tools to modify the specialized wheelchair. During an interview on [DATE] at 2:15 PM, CNA EE reported she had never been trained on the use of the EZ-lift machine used in Resident #11's room. CNA EE said she was not familiar with the specialized chair used by Resident #11 when going to outside appointments and did not know how to secure the headrest or the footrests. CNA EE admitted that she didn't know which loops to use for appropriate lifting of Resident #11 and said the loops initially chosen seemed too loose. CNA EE said she would ask a nurse or a CNA familiar with Resident #11's plan of care how to care for residents she was unfamiliar with. CNA EE said she had no idea staff other than therapy staff were expected to use tools to make modifications to a specialty chair. CNA EE said she wasn't sure what the facility policy was related to number of staff needed to complete a lift or transfer using a full lift machine, but was aware it depended on the resident whether or not more than one staff were needed to complete a full lift transfer, possibly based on weight or upper body strength. CNA EE did not reference utilizing the resident Care Guide/Kardex until prompted. During an interview on [DATE] at 4:00 PM, CNA Q reported she had only cared for Resident #11 once and explained she took the lead with operating the EZ-lift because she had seen it done before but admitted she had never been trained on the EZ-lift device used by Resident #11. CNA Q said she was confused about which loops to use to attach the sling to the EZ-lift. CNA Q said specialty chairs are NOT specified on the Care Guide used by nurse aides and admitted she was unfamiliar with the specialty chair used by Resident #11, its headrest and foot pedals. CNA Q said she was never told tools were available to modify specialty chairs. CNA Q did not reference utilizing the resident Care

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F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Guide/Kardex until prompted, instead reporting that any pertinent care needs were communicated in shift change report or on a Chart Sheet (paper guide used by CNA's to make notes about resident care). During an interview on [DATE] at 1:02 PM, OT J reported she had fitted Resident #11 in a tilt in space chair (the specialty chair observed on [DATE]) in September 2019. OT J said Resident #11 needed to use the headrest from his motorized wheelchair because it was longer and obtained allen wrenches to keep in a pouch attached to the cushion on his motorized wheelchair. OT J said she only trained two CNA's to use the tools to make the needed changes to Resident #11's chair and did not include specific instructions for other staff who may be less familiar with Resident #11 in case one of the other aides or she were not available to assist in the transfer. Resident #10 According to the Discharge Minimum Data Set (MDS) assessment, dated 2/12/2020, Resident #10 had multiple [DIAGNOSES REDACTED]. This same assessment indicated Resident #10 required extensive assistance of staff for moving in bed, dressing, using the bathroom and hygiene needs. Resident #10 was dependent upon others for transferring. Staff assessed Resident #10 as moderately cognitively impaired and Resident #10 had an activated Durable Power of Attorney for healthcare. On 2/12/2020, while on an outside appointment with the Responsible Party (RP) HH and in a personal vehicle, Resident #11 fell out of the wheelchair while the vehicle was moving. The RP HH reported they took Resident #11 to an appointment and while on the way back to the facility, the back had fallen off the chair and Resident #11 fell backward causing a fractured vertebra (bone in neck). Facility documents revealed the RP HH contacted the facility to report this incident shortly after it occurred. During an interview on [DATE] at 10:53 AM, Registered Nurse (RN) P revealed that the Responsible Party had obtained a personal vehicle to transport Resident #10 in January of 2020. RN P observed the Responsible Party taking Resident #10 on an outing for the first time on 1/25/2020. RN P stated that she had ensured the tie down straps were tight and instructed RP HH to keep the shoulder strap off Resident #11 as the strap fell across her neck and chin area. RN P then reported that she had never secured anyone in a vehicle while in a wheelchair. RN P denied having any training related to securing a wheelchair in a vehicle. During an interview on [DATE] at 2:15 PM, Chief Executive Officer (CEO) GG and Administrator (NHA), reported the education provided to RP HH was documented in a statement written and signed on 1/25/2020 by RN P. It was reported at this time that there was no additional documentation indicating that staff had educated and/or evaluated RP HH's ability to safely secure the wheelchair while transporting Resident #10. No further documentation was provided by the end of survey. Policies titled Physical Therapy (PT) Transfer Training and Occupational Therapy (OT) Transfer Training both revised 12/2/17, revealed that PT or OT staff were to evaluate a resident ability to safety transfer into a personal vehicle. Neither policy specifically referred to safely securing a wheelchair in a personal vehicle. The facility had no documentation indicating PT or OT staff evaluated Resident #10's safe transport while in a personal vehicle. During an interview on [DATE] at 2:15 PM the CEO GG and NHA stated there were no other policies directing staff to safely assess a wheelchair secured in a vehicle. During this same interview, it was discovered there was no education documented indicating staff were trained on how to safely secure a wheelchair in a personal vehicle. This surveyor asked for all requests for maintenance and repairs to Resident #10's wheelchair. The facility provided an invoice reflecting a repair by an outside company done on 12/2/19. Maintenance Z stated on [DATE] at 12:15 PM that facility staff would not perform any repairs on these types of chairs. The facility did not produce any additional documentation indicating staff were routinely performing safety checks on Resident #10's wheelchair. Resident #10's wheelchair Owner's Manual, no date, indicated that critical safety checks should be performed weekly, and at 3 and 6 months. Safety checks included visually check for loose hardware and Frame, Camber Tubes, and Crossbrace.