STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235014	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - REDFORD	25330 WEST SIX MILE ROAD REDFORD, MI 48240

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 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** Based on observation, interview, and record review the facility failed to provide nail care to one sampled Resident (#32) with a contracted hand, of three reviewed for activities of daily living (ADLs), resulting in long nails pressed into the impaired hand and potential for skin breakdown. Findings include: On 9/01/20 at 10:02 AM, Resident #32 was observed sitting in a wheelchair in the front lobby. Resident #32's right arm was observed inward touching their body, with the right hand into a close fist. Resident #32's right hand fingernails were not visible and curled under into Resident #32's palm. On 9/01/20 at 12:23 PM, Resident #32 was observed sitting in a wheelchair in their room with a lunch tray on a over bed table. Resident #32's right arm was observed inward touching their body, with the right hand into a close fist. Resident #32's right hand fingernails were not visible and curled under into Resident #32's palm. On 9/02/20 at 8:30 AM, Resident #32 was observed sitting in a wheelchair in their room with a breakfast tray on a overbed table with activities aide. Resident #32's right arm was observed inward touching their body, with the right hand into a close fist. Resident #32's right hand fingernails were not visible and curled under into Resident #32's palm. A review of Resident #32's medical record revealed the Resident was admitted to the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. On 9/03/20 at 11:40 AM, Nurse B was asked to observe Resident #32's impaired right hand. Nurse B gathered supplies and assisted Resident #32 to their room. Nurse B' was observed pulling Resident #32's hand open. Resident #32 yelled out in pain. Nurse B continued to pull open Resident #32's hand. Resident #32 grabbed at their right hand with their left hand and yelled out again. Nurse B cleaned Resident #32's hand. Resident #32's nails appeared to be long and pressed into the palm of Resident #32's hand. Nurse B was asked if Resident #32's nails were an appropriate length due to their hand being impaired. Nurse B stated, No, they (nails) are long. I will get someone to cut them. Nurse B was asked who was responsible for cutting Resident #32's nails. Nurse B stated, Certified Nursing Assistant or the Nurse. On 9/03/20 at 2:38 PM, the Director of Nursing was asked about Resident #32's long nails and explained, they are to be done with ADL care. They need to be cut to make sure they don't cut or dig into (Resident #32's) skin. A review of the facility's undated policy titled, Fingernail Care, noted, Purpose Care of fingernails promotes circulation to the hands and helps prevent small tears around the nails that could lead to infection. Finger nails are checked on shower days and trimmed as needed .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were repositioned timely (minimum of every two hours) for four sampled residents (R22, R30, R48, R55) of 15 reviewed for quality of care and repositioning, resulting in the likelihood of unmet care needs. Findings include: Resident #30 On 09/02/20 at 8:16 AM, R30 was observed seated in a wheelchair next to the side of the bed in their room. R30 was dressed, had a non slip sock on the left foot, a bandage on the right heel, the head was down with the chin to the chest and the head did not come up with a to knock on the door. R30 had a clothing protector (bib) on, with the call light clipped to left shoulder. On 09/02/20 at 9:28 AM, R30 was observed seated next to their bed in a wheelchair as before, head down, chin on chest, call light pinned to left, shoulder, clothing protector in place, non slip sock to left foot, right foot with bandage to right heel. On 09/02/20 at 10:24 AM, R30 was observed as before up in wheelchair. The aide for R30 reported a history of wounds to the left hip and tailbone with a current wound to the right heel. An over bed tray table was in front of the resident with a larger (burgundy colored) plastic container for water, and smaller clear plastic cup of type used for medication passes partially full with a clear liquid. On 09/02/20 at 11:49 AM, R30 continued to be seated in a wheelchair, head down chin to chest area, dressing visible to right heel, upon interview with R30, R30 reported to be up in the chair since out of bed and did not indicate they had been back to bed or assisted to the bathroom. R30 also noted the wound to the tailbone had healed up. R30 was observed not to had anything to drink as the paper remained on the tip of the straw for the water cup and the amount in the clear plastic cup was unchanged. R30 reported they drink when they want , but agreed they did not want to get dehydrated. On 09/02/20 at 12:36 PM, the lunch meal was delivered for R30. R30 continued to be seated in their wheelchair. R30 did not consume any of their lunch. R30 was more alert with eyes open and head moving around. R30 reported they did not eat due to no appetite. Tray removed by 2:52 PM. On 09/02/20 at 2:56 PM, R30 was observed to be seated in their wheelchair, at the side of the bed, with the tray table in front and with drink items on the table. On 09/02/20 at 4:05 PM, observed transfer with CNAs F and "G. The right heel wound was observed with drainage through bandage on the lateral side. R30 exhibited some moaning with movement. A lift was used to move R30 from the wheelchair to the bed. A view of the skin confirmed old wounds to the tailbone and left hip. It was then observed that the brief was wet (stripe had turned blue) as the CNAs were going to cover up R30 and it appeared the brief was not going to be changed. The CNAs were queried about the brief and then proceeded to change the brief of R30. It was confirmed by the CNAs that the brief was saturated with urine and had a small amount of stool. It was further reported on query that care had not been provided to R30 by CNA F since they came on shift at 2:30 PM. Nurse H and I were queried about the drainage observed on the right heel and later Nurse I reported this was confirmed and the dressing had been changed. On 09/02/20, a review of the clinical record for R30 revealed: R30 was admitted into the facility on [DATE]. [DIAGNOSES REDACTED]. A review of the Nursing Care Plan for R30 revealed: I am incontinent of Bowel and Bladder related to my impaired mobility. Date Initiated: 07/06/2020, Check me at least every two hours during the day and change my brief if needed. Date Initiated: 04/21/2020, I require supervision and assistance with ADL's. I have no plan for discharge at this time, I need assistance with my ADL's (related to) r/t B/L LE contractures, Eating: I need setup/supervision assistance by staff to eat. Date Initiated: 05/18/2020, Personal Hygiene: I need extensive assistance from you with personal hygiene and oral care. Date Initiated: 04/21/2020, Toilet Use: I need extensive assistance by you for toileting. Date Initiated: 04/21/2020, I have limited physical mobility r/t debility, bilateral LE contractures Date Initiated: 04/21/2020, I am at nutritional risk r/t poor appetite, debility Covid 19+. Requires a Mechanically altered diet r/t (difficulty swallowing) Dysphagia. I have increased nutrient needs r/t skin breakdown. Review 8-28-20: CBW 149#, weights stable. My appetite is good. I have diabetic ulcers to my (R)lat. heel and (R)lateral foot. Date Initiated: 04/21/2020, Observe and report (as needed) PRN any (signs/symptoms) s/sx of Dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in my mouth, Several attempts at swallowing and if I refuse to eat. Date Initiated: 04/28/2020 I have the potential for pain/discomfort r/t impaired mobility and pressure ulcers. Date Initiated: 05/01/2020, Evaluate the effectiveness of the interventions you provided to me to alleviate my discomfort. Date Initiated: 05/01/2020.

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) The Kardex (CNA care guide) revealed, Check me at least every two hours during the day and change my brief if needed. Keep me as clean and dry as possible . Resident R48 On 09/02/20 at 10:49 AM, 11:13 AM, 11:25 AM, 12:29 PM and 12:57 PM, R48 was observed to be in a low bed, mat on floor to left side, the right side of the bed against the wall. The tube feed pump was off, the head of bed (HOB) up around 30 degrees, suction set up in room and heel lift type boots are present in room, but not on R48's feet. The heels rested on the bed. A foam wedge was on the left side of R48, along the torso. On 09/02/20 at 3:01 PM, R48 was observed seated in medical recliner, heel protector boots not on. On 09/03/20 at 2:46 PM, on interview with the Director of Nursing (DON) the placement of the wedge and resident not repositioned were reviewed. The DON indicated the resident should be repositioned more often and the wedge was used for positioning not to keep R48 in bed. A review of the clinical record for R48 revealed: R48 was admitted into the facility on [DATE]. [DIAGNOSES REDACTED]. A review of the nursing care plan intervention dated 07/30/20 revealed: Bed Mobility: I require total assistance by staff to turn and reposition me frequently while in bed. The I have potential for impaired skin integrity care plan dated 08/05/20 revealed the intervention dated 08/20/20, Heel protectors to bilateral heels while in bed. Resident #20 On 9/01/20 at 10:28 AM, observed R20 in bed with their eyes closed, laying on their back. R20 responded to name called, however, was pleasantly confused and did not answer questions appropriately. On 9/01/20 at 12:55 PM, observed R20 in bed with their eyes open. Did not observed additional pillows or wafers at the bedside for repositioning. On 9/2/20 at 9:10 AM, observed R20 in bed on their back. On 9/2/20 at 011:25 AM, R20 was observed on their back. On 09/2/20 at 1:49 PM, R20 was observed on their back. On 9/3/20 at 9:02 AM, R20 was observed on their back. A review of R20's medical record noted [DIAGNOSES REDACTED].R20 requires extensive to total assistance by staff with all activities of daily living. A review of R20's care plan noted, Check me at least every 2 hours and change as needed .I require total assistance by staff to turn and reposition. Resident #55 On 9/1/20 at 10:20 AM, observed R55 in bed wearing a gown on their back. Attempted to ask R55, resident spoke with soft voice and did not answer questions appropriately. On 9/01/20 at 12:40 PM, R55 was observed in bed on their back. On 9/01/20 at 2:19 PM, R55 was observed in bed on their back. 09/02/20 09:05 AM observed resident in bed on back. 09/02/20 11:35 AM observed resident in bed on back. 09/02/20 01:53 PM observed resident in bed on back. A review of R20's medical record noted [DIAGNOSES REDACTED]. R20 requires extensive to total assistance by staff with all activities of daily living. A review of R20's care plan noted, Check me at least every 2 hours and change as needed .I require total assistance by staff to turn and reposition. On 9/3/20 at 2:47 PM, the Director of Nursing (DON) was queried about turning and repositioning. The DON stated, Residents that are not able to reposition on their own should be assisted by staff every two hours. A review of the facility's Turning a Dependent Resident Toward You noted the purpose: To reposition a resident for comfort or optimal skin care while maintaining good body alignment. The policy did not specify any additional information.
F 0686 **Level of harm** - Minimal harm or potential for 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** Based on observation, interview and record review the facility failed to perform and document wound care as completed affecting two residents (R54 and R216) of two residents reviewed for pressure ulcers with the likelihood of untreated wounds and perpetuation of wounds. Findings include: R54 On 09/01/20 at 1:30 PM, an interview was conducted regarding the care received at the facility. During the interview R54 sat up in bed and moved the covers to swing their legs over the edge of the bed. A dressing on the left hip dated 9/1 was observed. R54 was asked if the staff did wound care daily and said Yeah. On 09/02/20 at 8:39 AM, R54 was observed up in the wheelchair next to the bed and when greeted transferred back into bed. The left hip dressing was dated 9/2. On 09/03/20 at 10:23 AM, a wound care observation was conducted with Nurse A. Upon completion of the observation Nurse A was asked about wound care rounds and stated, The afternoon nurse usually does wound care in this house and I do them in the other house. (R54) is the only one over here and there is only one in the other house, but it's not a pressure ulcer. The Wound Care Nurse usually comes on Thursday but called in sick today. Record review of R54's Electronic Health Record (EHR) revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated , 08/07/2020 revealed R54 had a BIMS score of nine of 15 indicating a moderately impaired cognition and needed limited assistance to supervision with ADLs including bed mobility and transferring. Review of R54's Treatment Administration Record (TAR) revealed a treatment order for, [MEDICATION NAME] packing strips to left hip one time a day for wound care loosely packed after saline cleanse cover with dry dressing. In June 2020 the treatments were not documented on the TAR as completed on the 6th, 7th, 8th, 8th, 9th, 16th, 17th, 22nd, 27th, or the 29th. In July 2020 the treatments were not documented as completed on the TAR on the 20th, 24th, 25th, 27th, 28th, and the 30th. In September the treatment was not documented as completed on 9/1. R216 On 09/01/20 at 10:21 AM, An interview was conducted with R216 regarding the care received at the facility. During the interview R216 was observed to have wound care supplies on the bedside stand. R216 was asked about having pressure ulcers and stated, I had one on my bum but I think it's gone or almost gone. R216 was asked if the staff did wound care every day and stated, I don't think it was every day. Record review of R216's EHR revealed R216 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS assessment dated , 06/12/2020 revealed R216 had a BIMS score of 15 of 15 which indicated an intact cognition and needed extensive to total assistance with ADLs including bed mobility and transferring. Review of R216's TAR revealed a treatment order of, [MEDICATION NAME] Wound/Burn Gel (Wound Dressings) Apply to left Ischial (buttock) topically one time a day for abrasion after cleansing with saline and cover with dry dressing. In July 2020 the treatments were not documented as completed from July 20th to the 31st. In August 2020 the treatments were not documented as completed on the TAR on the 3rd, 4th, 6th, 7th, 8,th, 9th, 12th, 13th, 14th, 15,th, 16,th, 17th, 20th, 23rd, 28th, 29th, and 31st. On 09/03/20 at 11:30 AM, Nurse A was asked about the absence of documentation of the treatments being completed on the TARs and stated, (R216) has nothing down there now. I know that the treatments are done. I don't know why they aren't documented. On 09/03/20 at 2:32 PM, the Director of Nursing (DON) was a asked about the facility's policy and procedure regarding the documentation of pressure ulcer treatments on the TARs and stated, Ill have to looks at the policy. The facility's policy and procedure for documentation was requested on 09/03/2020 at 3:00 PM but not received by the end of the survey.
F 0688 **Level of harm** - 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** Based on observation, interview, and record review the facility failed to provide restorative therapy, access, monitor, and implement treatment for one sampled resident (#32) of six reviewed for limited range of motion, resulting in decreased range of motion and the development of right hand contractures. Findings include: On 9/01/20 at 10:02 AM, Resident #32 was observed sitting in a wheelchair in the front lobby. Resident #32's right arm was observed inward touching their body, with the right hand into a close fist. Resident #32's right hand fingernails were not visible and curled under into Resident #32's palm. Resident #32 hand was not observed with a hand brace/splint. On 9/01/20 at 10:10 AM, Certified Nursing Assistant (CNA J) was asked if Resident #32 had a hand splint or brace for their impaired hand. CNA J stated, No (R32) has never had one. On 9/01/20 at 12:23 PM, Resident #32 was observed with their right arm inward touching their body, with the right hand into a close fist. Resident #32 hand was not observed with a hand brace/splint. On 9/02/20 at 8:30 AM, Resident #32 was observed sitting in a wheelchair in their room with a breakfast tray on a overbed table with activities aide. Resident #32's right arm was observed inward touching their body, with the right hand into a close fist without a brace or splint present. A review of Resident #32's medical record revealed the Resident was admitted to the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Minimum Data Set (MDS) assessment dated , 4/9/19 noted, Resident #32 with an impaired cognition and required extensive assistance to perform Activities of Daily Living (ADLs). Functional limitation in range of motion marked as, No impairment - Upper and lower extremity upper extremity (shoulder, elbow, wrist, hand). A review of Resident #32's hospital referral 4/2/2019 noted, Physical therapy (PT) evaluation-Acute care . general observations of patient . right handed . with relevant history of hypertension; presented with neurologic symptoms of right [MEDICAL CONDITION], and we were consulted for possible stroke . (Resident #32) woke up at 5 or 6 am this AM and currently presents with right [MEDICAL CONDITION] arm > leg. Prior to presentation, the patient was on no med as a stroke preventive medication . (Resident #32) states prior never needed the assistance of a can or walker . Planned therapy interventions (PT) ROM . RUE (right upper extremity) grossly 1/5 with weak hand grip . Therapy screen assessment dated , 5/13/19

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F 0688 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) notes, Occupational therapy . 10. Joint contractures: impaired . 13. Opening/closing hands: WFL (Within Functional Limits). A review of the facility's therapy documentation revealed, Occupational Therapy (OT)Evaluation & Plan of Treatment: Certification period: 6/29/2020 - 7/28/2020 . RUE (Right Upper Extremity) Strength = Impaired, General RUE strength =2-/5; shoulder = impaired; elbow/forearm = impaired; wrist = impaired. Contractures: Functional Limitations Present d/t (do to) contractures = No. A review of Resident #32's referral for restorative therapy noted, Therapy to restorative nursing transfer form dated, 7/27/2020 Program goals: To prevent any RUE and lower extremity tightness. On 9/02/20 at 12:28 PM, Therapy Director was asked if Resident #32's had a brace or splint for their contracted hand. The Director of Therapy looked into Resident #32's medical record and reviewed the last discharge summary from Therapy dated 6/29 to 7/27 and explained, It does not look like contractor management was part of this case load. It was more for ADLs like self feeding. On 9/02/20 at 12:40 PM, Nurse B was asked if Resident #32 had a hand splint or brace for their contracted hand. Nurse B stated, (Resident #32) I don't think so. I don't remember ever seeing a brace on (Resident #32). On 9/03/20 at 10:06 AM, the Therapy Director, stated, I completed a screening for (Resident #32's) hand. I will be recommending OT to completed an eval for a hand brace. During the screening (Resident #32) was able to stretch out (their) arm, but had a hard time with (their) hand. The Therapy Director was asked if there was any screenings for Resident #32's right hand prior to this day, the Therapy Director stated, No. I did not see any. Resident #32's contracted hand had ever been addressed by therapy. The Therapy Director explained, they did not find any documentation regarding contractures management, only goals for ADLs. A review of the Therapy Director's screening revealed, Rehab admission screen: . 3. Does the patient require intervention for positioning or contractures? Yes. Comments: Evaluation by OTR recommended for R hand to assess for contractures and possible splinting. Signature: (Therapy Director) date: 9/2/2020. No other documentation was provided or found in the medical record that addressed Resident #32's right hand contractures. On 9/03/20 at 11:40 AM, Nurse B was asked to observe Resident #32's impaired right hand. Nurse B gathered supplies and assisted Resident #32 to their room. Nurse B' was observed to pull Resident #32's fingers out from a tight fist. Resident #32 yelled out in pain. Nurse B continued to pull open Resident #32's hand. Resident #32 grabbed at their right hand with their left hand and yelled out again. Nurse B cleaned Resident #32's hand. Resident #32's nails appeared to be long and pressed into the palm of Resident #32's hand. Further review of Resident #32's medical record revealed. Physician order: 7/28/2020 07:26 Restorative Weekly Progress Notes Note Text: Resident admitted to restorative nursing to prevent any right upper extremity and lower extremity tightness. On 9/3/20 at 1:04 PM, Nurse O was interviewed regarding Resident #32's restorative program, Nurse O stated, On 6/23/20 (Resident #32) was skilled before and was discharged from that and picked up for restorative. Nurse O read the order and stated, The Initial was on 7/27/20, admit to restorative three times a week for 12 weeks to prevent any right upper extremity and lower extremity tightness. Nurse O was asked how many aides worked in the restorative department. Nurse O explained the facility has one full time that was on vacation and one part time. Nurse O was asked for documentation of therapy and stated, That would be under task tab. Nurse O was observed to look in under the task tab and verified that a restorative tab was not located in that section for Resident #32 and stated, Let me go and see if this is where they document. I just became the Restorative Nurse today. On 9/03/20 at 1:42 PM, Nurse O stated, It looks like the task was not put into PCC (electronic medical record) for the CNAs (Certified Nursing Assistant) to document. Nurse O was asked if there was a way to know if was Resident #32 restorative was completed as ordered, Nurse O stated, According to the documentation no. On 9/03/20 at 1:43 PM, The Therapy Director provided documentation, I looked in the (electronic medical record) it looks like they only uploaded the Doctor signature page. Looking through the goals it does not look like there was any goals for contractor management or splinting. On 9/03/20 at 1:57 PM, MDS Nurse was asked if Resident #32 had a plan of care to address their contracted right hand or splinting. The MDS Nurse stated, We would do an assessment and determine the plan of care and document why or why not the splint is needed. On 9/3/20 at 2:38 PM, the Restorative Nurse Manager was asked for the process of for the Restorative program, the Nurse stated, We put the order in and it should be on the task tab for the CNA. The Restorative Nurse was asked the importance of the process, the Nurse stated, Ensure therapy is given as plan. I know they work with (Resident #32) but it's not documented. The Restorative Nurse was asked how does the facility monitor contractures for worsening, the Nurse stated, Weekly assessments and daily exercise with them. On 9/3/20 at 2:40 PM, the Director of Nursing was asked the facility's expectation for residents with hand contractures and if the facility used hand carrots (device that offers painless positioning of severely contracted hands for better patient comfort and easier caregiving.) The DON stated, Yes that (carrot) would be helpful. The DON was asked if a carrot required a physician order, the DON stated, No we can just do that. A review of the facility's policy titled, Establishing a Nursing Restorative Care Program dated, Identifying residents for the program: Residents who could benefit from receiving Nursing Restorative Care can be identified in the following ways: On admission, From information on the MDS, From the 24-hour report and change of shift report, At the facility's morning meeting, At care planning and other resident-focused meetings, At the weekly Quality of Life meeting, During daily rounds and Nursing Grand Rounds . Admission guidelines to restorative care Those who are ready to finish a skilled rehabilitation therapy program . Residents who require minimum to moderate assistance with standing, walking transferring, bathing, grooming, etc .
F 0692 **Level of harm** - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to ensure the provision of easily accessible fluids for residents reviewed for hydration, resulting in risk for impaired hydration not having fluids available in their rooms. Findings include: Resident #20 On 9/01/20 at 10:28 AM, observed R20 in bed with their eyes closed. R20 responded to name called, however, was pleasantly confused and did not answer questions appropriately. No observation of water or oral fluids in the room. On 9/01/20 at 12:55 PM, observed R20 in bed. Observed a 4oz glass of apple juice and a 4oz cup of orange juice. Both drinks appeared to be full. Did not observed water cup in room. On 9/2/20 at 9:10 AM, observed R20 in bed. Did not observed water cup in room. On 9/2/20 at 011:25 AM, R20 was observed in bed. Did not observed water cup in room. On 09/2/20 at 1:49 PM, R20 was observed in bed. Did not observed water cup in room. On 9/3/20 at 9:02 AM, R20 was observed in bed. Did not observed water cup in room. A review of R20's medical record noted [DIAGNOSES REDACTED]. R20 requires extensive to total assistance by staff with all activities of daily living. A review of R20's care plan noted, Assist me with meals. I have forgotten how to feed myself. Resident #58 Hydration Based on observation, interview, and record review, the facility failed to ensure the provision of easily accessible fluids for residents reviewed for hydration, resulting in risk for impaired hydration not having fluids available in their rooms. On 9/01/2020 at 01:30 PM, R58 was observed in their room sitting at the window visiting with family. Observed four less than half empty cups of fluids at R58's bedside, one cup was dated 8/31/20. On 9/2/20 at 9:18 AM, R58 was observed sitting at their bedside. Water was not observed at R58's bedside. R58 was queried if they had fresh water and R58 said, No, I don't have any water. On 9/2/20 at 11:45 AM, R58 was in bed with their eyes closed. Water was not observed at their bedside. On 9/02/20 1:50 PM, CNA J was interviewed and queried about residents receiving water. CNA J said, This place is a hot mess. They ran out of cups. I'm happy yall are here. They went out and got new mugs. They are too big for most of the residents to hold. On 9/3/20 at 2:47 PM, the Director of Nursing (DON) was queried about residents receiving water . The DON stated, The staff should be entering the room and offering water to everyone. A review of the facility's Hydration policy noted the following: Assure fresh bedside drinking water is available at all times .Offer and encourage fluids periodically.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain oxygen tubing in a safe manner affecting one resident (R35) of one resident reviewed for respiratory care with the likelihood of [MEDICAL CONDITION] (inadequate oxygen supply) and ineffective gas exchange. Findings include: On 09/01/20 at 10:12 AM, An interview was conducted with R35 regarding the care received at the facility. During the interview it was observed that R35 had a nasal cannula (for administering oxygen) and the other end was not connected to the oxygen concentrator. The connection end of the oxygen tubing was hanging from the bed. On 09/01/20 at 10:21 AM, Certified Nurses Aide (CNA D) was asked about the connection of R35's oxygen tubing to the concentrator and stated, It was connected, it must have pulled out when I got (R35) up in the chair. On 09/02/20 at 4:05 PM, R35 was observed reading in bed. The nasal cannula was properly placed in R35's nose but he connection end was lying on the floor in front of the concentrator. On 09/02/20 at 4:07 PM, CNA E was asked about the connection of R35's oxygen tubing and stated, I'll check it. CNA E then reconnected the tubing to the concentrator and moved the concentrator closer to R35's bed. On 09/03/20 at 9:09 AM, Nurse A was asked about R35's oxygen tubing being observed not being attached to the concentrator and stated, I've never seen it disconnected. I don't know if

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) she twists in bed, I'll get her longer tubing. Record review of R35's Electronic Health Record (EHR) revealed R35 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) dated , 07/20/2020 revealed R35 had a Brief Interview for Mental Status (BIMS) score of 13 of 15 indicating an intact cognition and needed extensive assistance with Activities of Daily Living (ADLs). Review of R35's care plan revealed interventions that included, OXYGEN SETTINGS: O2 via 2 L (liters) nasal canal and at all times, and Provide me with extension tubing or portable oxygen apparatus prn (as needed). On 09/03/20 at 2:32 PM, the Director of Nursing (DON) was asked about the facility's policy and procedure regarding oxygen therapy and stated, They should be checking that when rounding., Review of the facility's undated policy and procedure titled, Respiratory Equipment Care & Handling revealed 9. Disconnect used equipment and attach new equipment promptly. Attach resident and evaluate function. Ensure continuous oxygenation (for residents on oxygen.)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain sanitary food contact and non-contact surfaces, date mark food items once they are opened, discard food items before or on the date they expire, and sanitize thermometer probe in between taking food temperatures resulting in potential cross contamination and food borne illness. This deficient practice affects all 66 residents in the facility. Findings include: During the initial kitchen tour on [DATE] at 09:07 AM, the following was observed: 1. An opened half gallon of whole milk not dated in the reach-in refrigerator. When queried, the Certified Dietary Manager (CDM) P advised food items are normally dated with the open date. CDM also advised It was probably just opened today; I will make sure it gets dated. During review of the facility's Food Purchasing and Storage policy, it stated .6. All food items in refrigerators will be properly dated, labeled, and placed in containers with lids, or will be wrapped tightly. 2. Reddish brown liquid on the floor, a broom, and dustpan with trash debris in the corner of the protein cooler. During review of the facility's Food Purchasing and Storage policy, it stated .6. All walk-in freezers and refrigerators will be properly lit and clean. According to the 2013 FDA Food Code, ,[DATE].12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing. 3. A 5-pound bag of shredded mozzarella cheese with a date of [DATE]. When queried, CDM advised the date on the cheese is the receive date, not the opened date. 4. Condiments packets, paper debris, and brown sticky substance on the floor of the dry storage room. During review of the facility's Food Purchasing and Storage policy, it stated .3. Dry Storage: Floors will be swept clean at all times and mopped at least daily. 5. An opened liter of Pepsi, 20-ounce bottle of Pepsi, and a 20-ounce bottle of calypso unlabeled in the Mc Comber East satellite kitchen freezer. When queried, CDM P unable to verify if items belong to a resident or employee but did advise that resident's food is placed in the refrigerator as well. During review of the facility's Food from Outside Sources policy, it stated .4. Cleaning and food dating/labeling should be monitored daily. Food temperatures must be monitored in AM and PM. These tasks may be interdepartmental. 6. A box of unlabeled or undated food from Jets pizza, an unlabeled or dated sandwich from Wendy's, a dead gnat on the shelf, food debris and dry liquid in the McComber East satellite kitchen refrigerator. 7. A plastic bag at the bottle of the ice scoop holder. According to the 2013 FDA Food Code Section ,[DATE].12 In-Use Utensils, Between-Use Storage. During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: . (E) In a clean, protected location if the utensils, such as ice scoops, are used only with food that is not time/temperature for safety food. 8. An opened and undated cart of 32-ounce liquid whole eggs, an opened half gallon of 2% milk with an open date of [DATE] and use by date of [DATE], food debris, and dry liquid in the(NAME)house kitchen refrigerator. During review of the facility's policy Food Safety, it stated .4. Any food that has expired will be discarded immediately. According to the 2013 FDA Food Code, ,[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ,[DATE].17(A) or (B) shall be discarded if it: . (3) Is appropriately marked with a date or day that exceeds a temperature and time combination as specified in ,[DATE].17(A). On [DATE] at 12:09 PM during lunch observation in the McComber West satellite kitchen, observed the dietary aide S clean the thermometer probe with paper in between temping the lunch food items.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has four Deficient Practice Statements (DPS). DPS #1 Based on observation, interview, and record review the facility failed to perform hand hygiene in between glove changes during a wound care observation affecting one resident (R54) of two residents reviewed for pressure ulcers with the likelihood of the spread of infections. Findings include: On 09/03/20 at 10:53 AM, a wound care observation was conducted with Nurse A on R54. Nurse A knocked on the door, greeted the resident, explained the procedure, then washed hands appropriately and donned gloves. Nurse A asked R54 to roll over and removed the old dressing which was saturated with sero-sanguinous (blood tinged) drainage and changed gloves without hand hygiene. Nurse A then cleansed the wound as ordered and changed gloves without hand hygiene. Nurse A loosely packed the wound with medicated gauze as ordered and changed gloves without hand hygiene. Nurse A then secured the packing in the wound with dated border gauze. Nurse A then doffed the gloves and washed hands appropriately. Nurse A was asked what should have been done between glove changes and stated, I should have washed. On 09/03/20 at 2:32 PM, the Director of Nursing (DON) was asked about the facility's policy and procedure of hand hygiene in between glove changes and stated, They should have washed their hands. Review of the facility's undated policy and procedure titled, Hand Hygiene revealed, 4. Appropriate hand hygiene must be performed under the following conditions: t. After removing gloves or aprons. DPS #2 Based on observation, interview, and record review the facility failed to maintain urinary catheter drainage bags in a sanitary manner affecting two residents (R31 and R54) of two residents reviewed for urinary catheters with the likelihood of contamination of the catheter drainage bag and Urinary Tract Infections (UTIs). Findings include: R31 On 09/01/20 at 9:16 AM, R31 was observed in the dining room sleeping in a wheelchair. A urinary catheter drainage bag was observed suspended from the frame of the wheelchair and partially lying on the floor. On 09/01/20 at 10:12 AM, Nurse A was asked about the positioning of R31's catheter drainage bag and stated, It should probably not be on the floor. Record review of R31'2 Electronic Health Record (EHR) revealed, R31 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated , 07/09/2020 revealed R31 had a Brief Interview for Mental Status (BIMS) score of 13 of 15 indicating an intact cognition and needed extensive to total assistance with Activities of Daily Living (ADLs) including toileting. R54 On 09/01/20 at 10:31 AM, an interview with R54 was conducted regarding the care received at the facility. During the interview it was observed that R54 had a urinary catheter and the drainage bag was suspended from the frame of the wheelchair that was next to the bed and was partially on the floor. R54 was asked if the staff took care of the drainage bag and stated, Yes. On 09/02/20 at 08:39 AM, R54 was observed sitting up in the wheelchair next to the bed and the catheter drainage bag was partially on the floor. On 09/02/20 at 12:41 PM, R54 was observed lying in bed and the drainage bag was partially on the floor. On 09/03/20 at 8:20 AM, R54 was observed lying in bed and sat up when greeted. The catheter was secured to R54's leg and the drainage bag was completely on the floor. On 09/03/20 at 10:25 AM, an interview was conducted with Certified Nurses Aide (CNA C) regarding the placement and stated, They should not be on the floor. On 09/03/20 at 10:26 AM, an interview was conducted with Nurse A regarding R54's catheter drainage bag being observed touching the floor and stated, I have told the (staff) about that. They connect it to the wheelchairs crossbars and it slides down. Also (R54) transfers himself in and out of the bed. I will remind him to keep it off the floor. Record review of R54's EHR revealed R54 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated , 08/07/2020 revealed R54 had a BIMS score of nine of 15 indicating a moderately impaired cognition and needed limited assistance to supervision with ADLs including toileting. On 09/03/20 at 2:32 PM, the DON was asked about the facility's policy and procedure regarding catheter drainage bags and stated, They should not be on the floor. Review of the facility's undated policy and procedure titled, Indwelling Catheter Care revealed the suspension of the drainage bag above the floor was not addressed. DPS 3 Based on observation, interview and record review, the facility failed to follow professional standards of infection control by remove medical waste from R4 room resulting in the likelihood of the spread of infection and disease. Findings

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) include: On 9/01/20 at 10:08 AM, R4 was observed sitting in a wheelchair. R4 was observed with a LBKA (left [MEDICAL CONDITION]). Clothing was observed on the residents floor and bed linen on the closet floor. R4 said, They don't help me with this room. I also have two old wound vac (Vacuum-assisted closure of a wound). I had not used the wound vac in months, and they still have fluid in them. Observed [DEVICE] #1 in a clear plastic bag, in R4's closet with residual dried fluid in the tubing of the [DEVICE] and dried fluid particles fell from the inside of the bag onto the floor. R4 retrieved [DEVICE] #2 from a chair that had thicken bodily fluid in the drainage canister. (A [DEVICE] pulls fluid from the wound over time. This reduces swelling, and assist with wound cleaning and removal of bacteria. A [DEVICE] also helps pull the edges of the wound together. And it may stimulate the growth of new tissue that helps the wound close. A [DEVICE] system has several parts. A foam or gauze dressing is put directly on the wound. An adhesive film covers and seals the dressing and wound. A drainage tube leads from under the adhesive film and connects to a portable vacuum pump.) On 9/2/20 at 8:25 AM, a review of the electronic medical record noted R4 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A review of R4's wound care order dated 10/15/19 noted, Change wound vac every 3 days, ensure entire wound is filled with black foam and wound vac is set at 125mmg. Per the medical record, the [DEVICE] treatment was discontinued 1/10/2020. On 9/02/20 at 12:05 PM, the Director of Nursing (DON) was interview and queried about two contaminated [DEVICE] systems in R4's room. The DON said, The nurse should remove medical equipment when completed. The DON was queried about the discontinuation of the [DEVICE] and the DON stated, I think it was January (January 2020). On 9/02/20 at 12:18 PM, the Administrator was interviewed and queried about two contaminated [DEVICE] systems in R4's room since January 2020. The Administrator stated, Any equipment in the residents room that is not being used should be removed. A review of the facility's policy Infection Prevention and Control Program Overview noted: The infection prevention and control program is designed to identify and reduce the risk of acquiring and transmitting infection .The Infection Preventionist serves as the authority for overseeing the investigation, prevention and control of infections within the facility. Review food handling practices, laundry and linen handling practices, waste disposal . On 9/3/20 at 1:33 PM the Wound Vac policy was requested, however, the policy was not received. DPS 4 Based on observation, interview and record review the facility failed to ensure infection control practices were maintained during patient care and daily operations resulting in the potential for the spread of infection. Findings include: On 09/01/20 at 9:02 AM, the Transitional Care Unit (TCU) was observed. Nurse K was asked about the unit and reported the left side was the observation unit for residents transitioning from the hospital who may potentially have COVID. Nurse K reported staff would need a mask, face shield, gown and gloves for care of the residents. No active residents on the unit had COVID. The only sign for the unit was one on the left side of the closed double door which indicated it was the observation unit. No signs to indicate what isolations precautions to use were observed on this unit during the survey. On 09/01/20 10:10 AM, Nurse K, handed pills to the resident room [ROOM NUMBER] of the TCU observational unit without wearing gloves. On 09/01/20 at 10:22 AM, Therapist L was observed to assist (Certified Nurse Assistant) CNA M in room [ROOM NUMBER] of the TCU observational to put the legs of the resident back in bed. Therapist L did not have gloves on. On 09/02/20 at 10:30 the cover on the soap dispenser was off in room [ROOM NUMBER] which made the dispenser non functional and hands could not immediately be washed. On 09/02/20 at 11:01 AM, a housekeeper on the TCU observational unit, was noted in a room wearing a face shield, mask and gloves, but not a gown while cleaning. On 09/02/20 at 12:55 PM, a Certified Nurse Assistant on the TCU observational unit was observed to enter room [ROOM NUMBER], pick up a utensil and give a bite of food to the resident. The aide did not complete hand hygiene prior and did not put on gloves or a gown. On 09/03/20 at 9:20 AM, the soiled linen room was observed to have eight laundry bins of soiled linens. Four had bags of soiled linen two feet or higher above the tops of the bins. A pungent odor of stool and urine was noted. On 09/03/20 at 10:02 AM, a review of the infection control concerns and program was conducted with the Director of Nursing/Interim Infection Control Preventionist (IP). A review of the monthly summaries revealed the facility acquired infection rate had not been calculated for May, June and July of 2020 though the number of facility acquired infections was noted. The IP was asked about the concerns identified and reported: Gloves should be worn on the observation unit during resident care; If contact with a resident on the observation unit is necessary a face shield, mask, gown and gloves should be worn; the observation unit requires droplet precautions; the infection control rate should be calculated; They were not aware of the multiple bins of soiled linen, but did note some difficulty with enough laundry staff; And housekeeping is responsible for filling the soap dispensers. A review of the facility guidelines for the Surveillance Unit (not dated, page nine) indicated Full (personal protective equipment) PPE is required when caring for residents in Surveillance.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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** Based on observation and interview the facility failed to maintain the physical facility in good repair and sanitary conditions, resulting in an unpleasant, non-homelike environment. This deficient practice affects all 66 residents in the facility. Findings include: During an interview on 09/01/2020 at 01:10 PM with the Environmental Director R, he advised the porter normally checks the floor supply closets and fills them, but he has left for the day. On 09/01/20 at 01:26 PM observed the toilet tank top siting next to the toilet on the floor. When queried, Maintenance Supervisor Q advised he is not sure why the top is on the floor because there is no work order in the system for it, but he will ask one of the maintenance guys. On McComber: room [ROOM NUMBER]-1 had a circular pattern of peeling paint on the right side of the bed and two areas behind the head of the bead which had been scraped off to reveal a darker colored paint under the lighter colored wall paint.