STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235652	A. BUILDING _____ B. WING _____	03/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE TIMBERS OF CASS COUNTY	55432 COLBY ST DOWAGIAC, MI 49047

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 0582 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) for Medicare Part A services in 2 of 3 residents (Resident #17 & #90) reviewed for timely provision of notifications, resulting in the potential for the resident or resident representative to be unaware of changes in regard to financial liability, frustration, and a delay in the ability to file an appeal. Findings include: Review of the policy and procedure Medicare Denial Notification SNF ABN (CMS) and NOMNC (CMS), dated 10/1/16, revealed .To abide by the Social Security Act and protect beneficiaries and (Company Name), from unexpected liability for charges associated with claims that Medicare does not pay, and for the purpose of informing the Medicare Beneficiary .that Medicare certainly or probably will not pay for them on the particular occasion, the SNF will issue the Advance Beneficiary Notice (SNF ABN) .Also, to inform the beneficiary of his or her rights to an expedited review, the SNF will also issue the Notice of Medicare Non-Coverage (NOMNC) . Resident #17 Review of a Face Sheet revealed Resident #17 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of the Resident Census records revealed Resident #17 admitted with Medicare Part A as the primary payer source, and changed to Private Pay on 10/18/19. Note Resident #17's last covered day for Medicare Part A services was on 10/17/19. Review of a SNF Beneficiary Protection Notification Review form completed by the facility for Resident #17 revealed .The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted . No documentation was provided by the facility to show that a SNF ABN form and a NOMNC form were provided to Resident #17 in a timely manner prior to the discontinuation of Medicare Part A coverage. Resident #90 Review of a Face Sheet revealed Resident #90 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of the Resident Census records revealed Resident #90 readmitted to the facility on [DATE] with Medicare Part A as the primary payer source, and changed to Medicaid on 10/23/19. Note Resident #90's last covered day for Medicare Part A services was on 10/22/19. Review of a SNF Beneficiary Protection Notification Review form completed by the facility for Resident #90 revealed .The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted . No documentation was provided by the facility to show that a SNF ABN form and a NOMNC form were provided to Resident #90 in a timely manner prior to the discontinuation of Medicare Part A coverage. In an interview on 3/17/20 at 9:16 a.m., Minimum Data Set Registered Nurse (MDS RN) H reported she is responsible to provide the SNF ABN and NOMNC forms to residents discharging from Medicare Part A services, and reported she was unaware that the SNF ABN forms were necessary for residents remaining in the facility. MDS RN H reported no SNF ABN forms or NOMNC forms were provided to Resident #17 prior to her payer source change on 10/18/19 or Resident #90 prior to her payer source change on 10/23/19. In an interview on 3/17/20 at 12:11 p.m., MDS RN H reported corporate sends her the NOMNC forms for residents with Managed Care insurance, however residents with Medicare Part A as a primary payer were not receiving the NOMNC forms because she was not aware of the requirement.
F 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment after a change in health status, in 1 of 20 residents (Resident #71) reviewed for significant changes in physical or mental condition, resulting in the potential for unassessed physical, mental, emotional, and psychosocial needs. Findings include: Review of the October 2019 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.17.1, Chapter 2: Assessments for the Resident Assessment Instrument (RAI), revealed .The SCSA (Significant Change in Status Assessment) is a comprehensive assessment for a resident that must be completed when the IDT (Interdisciplinary Team) has determined that a resident meets the significant change guidelines for either major improvement or decline .A significant change is a major decline or improvement in a resident's status that .1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting .2. Impacts more than one area of the resident's health status; and .3. Requires interdisciplinary review and/or revision of the care plan .An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD (Assessment Reference Date) must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill . Review of a Face Sheet revealed Resident #71 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of the Resident Census records revealed Resident #71 was enrolled in Hospice from 5/7/18 through 10/12/19, and changed to Medicaid as the primary payer source on 10/13/19. Review of the Physician order [REDACTED].Discharge from hospice Saturday midnight . dated 10/13/19. Review of a Progress Note for Resident #71, dated 10/13/19, revealed .Resident remains on hospice care. Able to make needs known. Denied pain. No apparent distress. Effortless breathing. Call light within reach . Note this is a discrepancy as Resident #71 was discharged from Hospice as of 10/13/19 per the Physician Orders. Review of a Progress Note for Resident #71, dated 11/5/19, revealed .Residents (sic) was d/c (discharged) from hospice this quarter . Review of a Progress Note for Resident #71, dated 11/7/19, revealed .Resident slept well and has voiced no complaints this shift. Remains on Hospice Services . Note this is a discrepancy as Resident #71 was discharged from Hospice as of 10/13/19 per the Physician Orders. Review of a Progress Note for Resident #71, dated 12/11/19, revealed .Continues on Hospice care . Note this is a discrepancy as Resident #71 was discharged from Hospice as of 10/13/19 per the Physician Orders. Review of the Minimum Data Set (MDS) Assessment record for Resident #71 revealed Quarterly MDS Assessments were completed with reference dates of 8/9/19, 11/2/19, and 1/31/20. Note no Significant Change in Status Assessment (SCSA) was completed after Resident #71 discharged from Hospice in October 2019. Review of a Quarterly MDS Assessment, with a reference date of 11/2/19, revealed Resident #71 was not identified as having received Hospice care in the past 14 days. Review of a Quarterly MDS Assessment, with a reference date of 1/31/20, revealed Resident #71 was identified as having received Hospice care in the past 14 days. Note this is a discrepancy based on the information above. In an interview on 3/17/20 at 1:02 p.m. Minimum Data Set Registered Nurse (MDS RN) I reported both enrollment and discharge from Hospice would trigger staff to complete a SCSA because .you would have to review and update all the care plans . MDS RN I reported Resident #71 is no longer receiving Hospice services, and that a SCSA should have been completed. MDS RN I reported she is notified of changes in Hospice status during the morning meetings, and reported she was unsure how Resident #71's SCSA was missed.

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

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F 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)

F 0678

Level of harm - Immediate jeopardy

Residents Affected - Few

Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

This citation pertains to intake #MI 829. Based on interview and record review, the facility failed to perform the [MEDICATION NAME] Maneuver per American Heart Association (AHA) standards prior to the arrival of Emergency Medical Services (EMS) personnel for 1 of 4 residents (Resident #37) reviewed for accidents and hazards, when Resident #37 was found by Certified Nursing Assistant (CNA) QQ gasping for air and assumed to be choking on [DATE] at approximately 5:55 P.M. This resulted in an Immediate Jeopardy when Resident #37 became non-responsive and Registered Nurse (RN) P, Director of Nursing (DON) B and Licensed Practical Nurse (LPN) S subsequently administered the [MEDICATION NAME] Maneuver inadequately without lowering Resident #37 to the ground or performing chest thrusts. Resident #37 was pronounced dead at 6:20 P.M. This deficient practice placed all 98 residents, at risk for serious harm, injury, and/or death. On [DATE], the Nursing Home Administrator A was notified of an Immediate Jeopardy that began on [DATE] when Resident #37, who was identified to be choking and unresponsive was not administered the [MEDICATION NAME] Maneuver per AHA standards, and staff were found to be not adequately trained per facility policy. Findings include: Review of the facility policy Medical Emergency Response Revision ,[DATE] revealed, Emergency Response Team: Consists of the highest level nurse supervisor in the building, the nurse assuming care of that resident for that day, at least one nursing assistant and one member to make the 911 call and coordinate other communications Training and Education: 1. All licensed nurses will remain current in AHA Basic Life Support (BLS) CPR (Cardiopulmonary Resuscitation) and AED (Automated External Defibrillator) for healthcare providers certification. Review of the facility policy CARDIOPULMONARY RESUSCITATION Revision ,[DATE] revealed, Purpose:

The purpose of this policy and procedure is to ensure the facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with resident's physician orders, such as DNR (Do Not Resuscitate)/Full Code, and the resident's advance directives. The facility will provide consistent and appropriate response to emergency situations, to provide basic life support (BLS) that is consistent with acceptable practice standards held by the American Heart Association (AHA). AHA publishes guidelines every 5 years for CPR and Emergency Cardiovascular Care (ECC). These guidelines are evidenced-based decision-making guidelines for initiating CPR when cardiac or respiratory arrest occurs. This facility and facility staff will follow these guidelines .B. Certification / Training of Staff

*Licensed Nurses providing direct resident care including supervision and/or delegation responsibilities will have a current and valid CPR certification from American Heart Association for healthcare providers upon hire. * The facility will track and monitor licensed nurse CPR certification annually with nurse licensure tracking. There is no grace period for expired CPR certification; nurses will be removed from the schedule until they obtain a current healthcare provider CPR certification. * (Company name eliminated) communities will consistently follow the American Heart Association (AHA) guidelines for Basic Life Support (BLS) or follow Emergency Cardiac Care (ECC). These guidelines reflect global resuscitation science and treatment recommendations. According to National Center for Biotechnology Information-Abdominal Thrust Maneuver ([MEDICATION NAME]) last updated [DATE], .Today, the [MEDICATION NAME] maneuver is accepted and taught during BLS and ACLS for conscious adults, but backslaps are still recommended for infants and chest compressions are recommended for unconscious patients Although there are no absolute contraindications, the abdominal thrust maneuver is not recommended by the AHA for infants or unconscious patients .Cases of choking happen in mere seconds and unexpectedly, making preparation nearly impossible. As mentioned above, the [MEDICATION NAME] maneuver is taught during BLS for the conscious choking adult. According to American Heart Association-2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care Originally published [DATE] (https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.110XXX 9) Foreign-Body Airway Obstruction (Choking) FBAO is an uncommon, but preventable, cause of death. Most reported cases of FBAO occur in adults while they are eating. Most reported episodes of choking in infants and children occur during eating or play when parents or childcare providers are present.

The choking event is therefore commonly witnessed, and the rescuer usually intervenes while the victim is still responsive. Treatment is usually successful, and survival rates can exceed 95%. Recognition of Foreign-Body Airway Obstruction Because recognition of FBAO is the key to successful outcome, it is important to distinguish this emergency from [MEDICAL CONDITIONS], or other conditions that may cause sudden respiratory distress, cyanosis (bluish or purplish discoloration of the skin or mucous membranes due to lack of oxygen), or loss of consciousness. Foreign bodies may cause either mild or severe airway obstruction. The rescuer should intervene if the choking victim shows signs of severe airway obstruction.

These include signs of poor air exchange and increased breathing difficulty, such as a silent cough, cyanosis, or inability to speak or breathe . Relief of Foreign-Body Airway Obstruction When FBAO produces signs of severe airway obstruction, rescuers must act quickly to relieve the obstruction. If mild obstruction is present and the victim is coughing forcefully, do not interfere with the patient's spontaneous coughing and breathing efforts. Attempt to relieve the obstruction only if signs of severe obstruction develop: the cough becomes silent, respiratory difficulty increases and is accompanied by stridor (a high pitch, [MEDICATION NAME] sound heard when taking a breath), or the victim becomes unresponsive. Activate the EMS system quickly if the patient is having difficulty breathing. If more than one rescuer is present, one rescuer should phone 911 while the other rescuer attends to the choking victim .If the adult victim with FBAO becomes unresponsive, the rescuer should carefully support the patient to the ground, immediately activate (or send someone to activate) EMS, and then begin CPR. The healthcare provider should carefully lower the victim to the ground, send someone to activate the emergency response system and begin CPR (without a pulse check). After 2 minutes, if someone has not already done so, the healthcare provider should activate the emergency response system. A randomized trial of maneuvers to open the airway in cadavers and 2 prospective studies in anesthetized volunteers showed that higher sustained airway pressures can be generated using the chest thrust rather than the abdominal thrust. Each time the airway is opened during CPR, the rescuer should look for an object in the victim's mouth and if found, remove it. Simply looking into the mouth should not significantly increase the time needed to attempt the ventilations and proceed to the 30 chest compressions . Review of a Face Sheet revealed Resident #37 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Progress Note dated [DATE] at 06:42 P.M. revealed, (Resident #37) observed unresponsive with food particles in her mouth at 5.55pm. Resident had pulse at the time but not breathing. [MEDICATION NAME] maneuver procedure conducted immediately. Resident suctioned with a few food particles noted. Resident maintained a steady pulse throughout the procedure. Supplemental oxygen initiated concurrently. Staff called EMTs (Emergency medical Technician) who arrived at 6.10pm. The EMTs staff attempted to remove food particles and stated that the airway was clear with agonal (life threatening-abnormal) pulse rate. No CPR attempted d/t resident's DNR (Do Not Resuscitate) status. At 6.20pm, resident had no pulse and no respirations. This was confirmed by 3 RNs present at the time. Note that this document did not include vital signs or blood sugar levels. During an interview on [DATE] at 10:59 A.M., DON B recalling the events that led up to Resident #37's death on [DATE] reported, that it was supper time and Resident #37 was eating in her room when a CNA noticed that she was unresponsive, so the CNA called for a nurse. DON B then reported that they started doing the [MEDICATION NAME] Maneuver because they could see food and thought something was stuck in her throat. DON B reported that the nurses performed the [MEDICATION NAME] Maneuver and used the suction tool, but nothing came out. DON B reported that Resident #37 had a pulse, but was not breathing. DON B reported that EMS arrived and they did not see any obstruction. DON B reported that there was no progress report from EMS because they did not do anything. During an interview on [DATE] at 02:15 P.M., CNA QQ reported that on [DATE] she had brought Resident #37 her dinner meal and Resident #37 sat up in her bed to eat independently, then CNA QQ returned a couple minutes later with a drink, and found Resident #37 gasping for air, with her eyes wide open and face color bluish-purple. CNA QQ reported that she yelled down the hall for help and RN P came into the room and then RN P immediately left the room to page others to assist. CNA QQ reported that RN P and some other nurses sat Resident #37 up and did the [MEDICATION NAME] Maneuver, but were not successful at getting the food out. CNA QQ reported that EMS arrived a few minutes later and were able to remove the food, but it was too late. During an interview on [DATE] at 12:34 P.M., RN P reported that on [DATE] at 5:55 P.M. she was called into Resident #37's room in response to CNA QQ's call for help. RN P reported that Resident #37 was lying flat in her bed, her face was blue, eyes open and her mouth wide open (RN P demonstrated this expression). RN P reported that she could feel Resident #37's pulse at that time, but Resident #37 did not respond to her voice, therefore RN P immediately went into the hall to page all available nurses to come help.

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) RN P recalling the events reported that she saw food in Resident #37's mouth and removed it with her fingers and then raised the head of the bed so that Resident #37 was in a sitting position. RN P reported that at that time Resident #37's body was limp and RN P was holding her up in a sitting position, patting her on the back and then stood behind Resident #37 and performed the [MEDICATION NAME] Maneuver (RN P demonstrated wrapping her arms around this surveyor and simulating abdominal thrusts.) RN P reported that Resident #37's head was hanging down limp during that time. RN P reported that several other staff arrived, and then we used the suction to remove food in Resident #37's mouth, held oxygen to her nose and did more abdominal thrusts in the sitting position. RN P reported that during these events Resident #37 remained unresponsive, in her bed in a sitting position, or held in a sitting position by staff. RN P then reported that EMS arrived and looked in Resident #37's mouth, said that it was clear but that her pulse was getting weak. RN P reported that EMS wasn't able to do anything else because Resident #37 was DNR. During an interview on [DATE] at 01:27 P.M., DON B reported that when he entered Resident #37's room on [DATE], RN P, LPN S, RN O and some CNA's were in the room already. DON B reported that Resident #37 was lying on her back in bed with the head of the bed raised and the nurses were suctioning Resident #37's mouth. DON B reported that using the suction tool after performing the [MEDICATION NAME] Maneuver, would be expected of the nurses, when they observe that a resident is eating and then starts gasping or stops breathing and the nurses suspect that food was caught in the airway. DON B reported that the [MEDICATION NAME] Maneuver was performed by several people .(LPN S) performed and I observed. DON B reported that Resident #37 was being held in a sitting position in her bed during the [MEDICATION NAME] Maneuver. DON B reported that EMS arrived and used a light to look down her throat and reported that it was clear. DON B reported that EMS did not administer breaths, that would be CPR, but they used the facility's Ambu Bag (a hand-held device used to provide positive pressure ventilation to patients who are not breathing) to verify that Resident #37's airway was clear. DON B reported that there was no incident report completed by the facility. DON B reported that there was no report indicating a timeline or measures that were taken leading up to Resident #37's death, stating we only do that when CPR is performed. During an interview on [DATE] at 02:24 P.M., LPN S reported that he entered Resident #37's room on [DATE] in response to RN P's overhead page for assistance, Resident #37 was lying on her back in bed with the head of the bed raised into a sitting position, LPN S stated Resident #37 did not look good, but she had a pulse. LPN S reported that first we checked her blood sugar level and when that was not concerning at 289, we thought blocked airway. LPN S reported that he did not see any food in her mouth, but the suctioning tool was used to see if there was any food back farther. LPN S reported that the suctioning tool was inserted down Resident #37's throat until it couldn't go further and only small particles of food were coming out. LPN S reported that DON B then entered the room and performed the [MEDICATION NAME] Maneuver to Resident #37 by standing behind her and administering abdominal thrusts, while LPN S and RN P were holding Resident #37 in a sitting position in her bed and using the suction tool in Resident #37's mouth. LPN S then reported that LPN S and DON B switched positions and LPN S performed the [MEDICATION NAME] Maneuver to Resident #37. LPN S reported that Resident #37 remained in a sitting position and did she not respond to the [MEDICATION NAME] Maneuver or the suctioning measures being performed. LPN S reported that they, hooked oxygen to the Ambu Bag and administered breaths to Resident #37, but did not observe rise and fall of her chest, and therefore suspected that there was still a blockage. LPN S reported EMS then arrived and laid Resident #37 completely flat in her bed, opened her mouth and used a laryngoscope (device used to view the throat), and were able to see a piece of food blocking her airway. LPN S reported that EMS used forceps (a handheld tool used for grasping objects) and the facility's suction tool and were able to retrieve a piece of hash brown. LPN S reported, then the Ambu bag was used again to deliver a couple of rescue breaths and Resident #37's chest did rise and fall, and her heart rate was faint. LPN S reported that no further measures were taken to resuscitate Resident #37's due to her code status of DNR. During an interview on [DATE] at 04:08 P.M., Family Member III reported that she was notified by the facility on [DATE] that Resident #37 had passed away after she was found choking. FM III reported that the facility explained to her that they had found food down deep in Resident #37's throat, and that Resident #37 was likely coughing while she was eating which lead to her choking to her death. FM III reported that Resident #37's death was a shock to the family because Resident #37 was in good health. Review of Resident #37's EMS Report dated [DATE] revealed, Dispatched to the local nursing home for a resident in [MEDICAL CONDITION]. Upon arrival to scene we find a [AGE] year-old female being held in a sitting position by facility staff. Report received was that the patient was found when her aide came to collect her dinner tray. Per report patient was found to be apnic (sic) (without breathing) with a pulse. Per report multiple attempts were made to clear the airway with the [MEDICATION NAME] maneuver that were unsuccessful. Exam found the patient in a sitting position with staff supporting her with her head all the way forward. Patient was placed into a reclined position and her head repositioned to facilitate proper airway positioning. No change in respiratory status after repositioning. Laryngoscope used to visualize the airway and a large piece of food was found to be occluding (obstructing) the vocal cords. With the use of the Magill forceps and suctioning the obstruction was removed. BVM (bag valve mask) ventilations (introduction of air) now successful with good chest rise noted. A valid DNR was presented and a four lead EKG (heart monitor) was obtained. Patient was found to be in agonal (life threatening-abnormal) rhythm at 25 BPM (beats per minute). Medical control contacted and advised of the situation, treatment rendered and the result of said treatments. Medical control also advised of DNR. Medical control also advised that the facility would handle the death of the resident in-house according to their SOP (standards operating procedure). Medical control advised that was acceptable. During an interview on [DATE] at 11:32 A.M., EMS MMM reported upon arrival on [DATE], staff had reported that Resident #37 had a blocked airway and they had tried the [MEDICATION NAME] Maneuver without success and Resident #37 was being held in a sitting position in the middle of her bed by staff with her head hanging down. EMS MMM reported that the first priority was to open the airway, therefore EMS MMM held Resident #37's head up and then positioned her in a reclined position on the bed. EMS MMM reported that a laryngoscope was used to visualize Resident #37's throat and a large piece of food was visualized obstructing the vocal cords. EMS MMM reported that by using forceps, the facility's suctioning tool, and the help of LPN S, the piece of food was removed. EMS MMM reported that the facility's Ambu Bag was used to deliver breaths and to confirm that the airway was now clear. EMS MMM reported that an heart monitor was attached to Resident #37 and showed an agonal rhythm. EMS MMM reported at that time, the facility presented a DNR order, then EMS MMM called the hospital to obtain further instruction and the hospital advised EMS MMM to not provide any further treatment for [REDACTED]. During an interview on [DATE] at 01:27 P.M., DON B reported that it is a requirement of the facility that all licensed nurses have a current certification for Basic Life Support including CPR and [MEDICATION NAME] Maneuver, but that some nurses may not have a current certification. DON B reported that this information is kept in a binder with the Human Resources department. During an interview on [DATE] at 8:55 A.M., Minimum Data Set Registered Nurse (MDS RN) H reported there were no current Basic Life Support (BLS) certifications for RN P, DON B, or RN O. During an interview on [DATE] at 10:10 A.M., DON B reported Basic Life Support (BLS) Certifications for the nursing staff are monitored by Staff Development Coordinator K. During an interview on [DATE] at 10:56 A.M., Staff Development Coordinator K reported DON B was responsible for monitoring nursing licenses and BLS Certifications for upcoming expiration dates. During an interview on [DATE] at 1:42 A.M., DON B reported there was no vital sign documentation for Resident #37 in [DATE]. DON B reported the blood sugar level obtained for Resident #37 during the choking incident on [DATE] should be documented in the progress notes. Review of Vital Signs for Resident #37 revealed, no documentation of vital signs for [DATE]. Review of Blood Sugar Results and Progress Notes for Resident #37 revealed, no documentation of blood sugar levels for [DATE] during the time of the facility's emergency response (approximately 5:55 P.M.) On [DATE], the survey team verified the facility completed the following to remove the Immediate Jeopardy. The facility immediately completed the following actions: * At 1:00 PM on [DATE] a review of all personnel records were reviewed to determine staff AHA 2010 CPR certification status * AT 1:30 PM on [DATE] the staffing schedule was updated to ensure 2010 AHA CPR certified staff are scheduled and available in the facility 24 hours a day * At 1:30 PM on [DATE] (Educator LLL) was contacted to schedule CPR training and certification for all licensed nurses in the facility. The training will meet 2010 American Heart Assoc. standards. * Training for CPR certification is scheduled for [DATE] for all uncertified Nurses to be certified. * On [DATE] the CNA's and Licensed Nurses who were working on shift were trained on the [MEDICATION NAME] maneuver, this included return demonstration and given a test, by (RN MMM). This training will meet 2010 American Heart Assoc. standard. * Ongoing, (UM Q), will train the CNA's and Licensed Nurses on the [MEDICATION NAME] maneuver, including a return demonstration and test, prior to working their next shift. * On [DATE] competencies were completed to ensure non-licensed nursing personnel were aware of their expected role in emergency response procedures and in the [MEDICATION NAME] maneuver in accordance with the 2010 American Heart Association standards and the facility policy. Attach: CPR Policy, Medical Emergency Response Policy The following will commence immediately on [DATE] and all dates forward: 1. CPR certified staff will be available in the facility 24 hours per day. 2. Licensed nurses

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) will be required to submit a copy of CPR certification to the facility Human Resources Director to be kept in a CPR binder which will be tracked by (DON B) to ensure nurses remain current in CPR certification. 3. The facility Human Resources Director will maintain a tickler file on Licensed Nurses CPR Certifications and will notify them 1 month prior to their certification expiration. 4. Nurses who allow CPR certification to lapse will not be allowed to return to work until the certification is received by the facility. 5. Newly hired nurses will not be allowed to work until current CPR certification is received for placement and tracking in the CPR binder in the Human Resources office. Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance with a scope of isolate and severity of actual harm due to all nursing staff had not received training for CPR/[MEDICATION NAME] Maneuver and sustained compliance had not been verified by the state agency.
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** This citation pertains to intake #MI 910. Based on observation, interview, and record review, the facility failed to provide and document appropriate treatment for 1 resident (Resident #89) of 4 residents reviewed for quality of care in a total sample of 20 residents resulting the resident not receiving appropriate interventions. Findings include: Review of the Face Sheet revealed Resident #89 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #89, with a reference date of 02/16/20 revealed a Brief Interview for Mental Status (BIMS) score of 8 out of a total possible score of 15, which indicated Resident #89 was moderately cognitively impaired. In an observation on 03/11/20 10:28 AM, Resident #89 was observed sitting in his wheelchair in the television area by the nurse's station with a bandage on top of his right hand with no date or time noted on the bandage. In an observation on 03/11/20 11:43 AM, Resident #89 was observed sitting in his wheelchair in the television area by the nurse's station with a bandage on top of his right hand with no date or time noted on the bandage. Review of Progress Note for Resident #89 dated 03/06/2020 at 02:52 PM, .Skin tear also noted to top of right hand, cleansed with saline bordered gauze applied . Review of Progress Notes for Resident #89 dated 03/08/202 at 04:10 PM, .Dressings to right hand and right knee changed . Review of Progress Notes for Resident #89 dated 03/11/2020 at 03:01 PM, .Dressing to right hand changed . In an observation on 03/12/20 at 2:06 PM, the bandage on Resident #89's top right hand was dated 03/11/20 at 13:20 PM. Review of Progress Notes for Resident #89 dated 03/12/2020 at 02:51 PM, .Dressing to right hand clean, dry and intact . Review of Resident #89's Treatment Administration Record (TAR) showed no notation of an order to provide wound care treatment for [REDACTED]. In an interview on 03/13/20 02:40 PM, Unit Manager J reported there are standing orders for when there is a skin tear and it should have been created, printed, and placed in the Treatment Administration Record (TAR) by the responsible nurse. In an interview on 03/13/20 02:40 PM, Unit Manager J stated, .It was an oversite . Review of S.O. (Standing Order) -Wound Order revealed, .Skin Tear: Minor- Cleanse area w (with)/normal saline, pat dry, apply non-adherent drsg(dressing) or steri strip .Frequency: Once a day .
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 interview and record review the facility failed to identify a significant weight change and assess the need for interventions for this weight change, for 1 of 4 residents (Resident #23), reviewed for nutritional status, resulting in the potential for further unrecognized weight loss and decline in health. Findings include: Review of the facility's Weight and Height Records policy and procedure, revised 1/2019, revealed .all residents' height and weight will be determined by appropriate methods .Weight will be measured monthly. The Weight changes of all residents will be monitored monthly. Percentage weight changes will be determined for 30-day, 90-day, and 180-day periods .Unplanned or unresolved weight loss: .Those residents that trigger for a significant weight loss (greater than) 5% from the previous month will be placed on weekly weights .Each resident will be reviewed by the IDT (interdisciplinary team) committee and appropriate interventions will be put in place .Prior to the end of each month, the facility (registered dietician/certified dietary manager .) will provide the DON (director of Nursing) a list of those residents identified and tracked .The (registered dietician/certified dietary manager .) must document on weight gains and losses of those residents that experience 5% for 30 days, 7.5% for 90 days and 10% for 180 days in the medical record to meet the professional standards for Dietitians .Re-weights: conducted on residents that: .Have experienced a 5% weight gain or loss from the previous month .Nursing services is responsible to obtain monthly weights on each resident .The results are given to the DON, designee .A weight report will then be printed indicating the following weight variances .2% in 1 week .5% in 1 month . 7.5% in 3 months .10% in 6 months . Resident #23 Review of the facility Admissions Record revealed Resident #23 was a [AGE] year-old female originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS), on 12/15/19, revealed Resident #23 was moderately cognitively impaired. Review of Resident #23's monthly weight records obtained from the electronic medical record (EMR) Vital Signs tab, revealed on 1/15/2020, the resident weighed 145.3 pounds. On 2/7/2020, Resident #23 weighed 136.4 pounds which was a -6.13 % weight loss in one month, indicating a significant weight change (-5% in 1 month). This weight was highlighted red, indicating a significant weight change alert. On 12/11/2019, Resident #23 weighed 146.6 pounds. On 3/6/20, Resident #23 weighted 134.6 pounds, which was a -8.19 % weight loss in 3 months, indicating a significant weight change (-7.5 % significant in 3 months). Review of Resident #23's Care Plan focus Nutritional Status revealed .Resident is at nutritional/hydration risk .Observe tolerance to diet, make adjustments PRN (2/2/16) .RD to review PRN (2/2/16) . In an interview on 3/13/20 at 2:00 PM, Dietary Manager WW (DM) and Assistant Dietary Manager YY (ADM) indicated once a week ran a weight variance report prior to the weekly SOC (standard of care) meeting that occurred every Wednesday. DM WW' reviewed weight variance report records and indicated Resident #23 did not appear on February 11th's weight variance report for significant weight loss. DM WW reviewed Resident #23 monthly weight record, under Vital Signs in the EMR. DM WW verified Resident #23's, 2/7/20, weight was a significant loss of 5% in 1 month and the weight change was highlighted red in the EMR as an alert. DM WW indicated Resident #23's significant weight change was not identified, Resident #23 was not reweighed, Resident #23 was not assessed by the nursing staff or dietician, and no new dietary interventions were included in her care plan since 1/2/19 (over a year prior). DM YY indicated was not able to go to all the SOC meetings due to resident care conferences. DM YY indicated nursing services should be pulling the weight variance list if dietary could not attend. In an interview on 3/17/20 at 9:30 AM, DON B indicated had a SOC meeting every Wednesday. DON B indicated SOC met on 2/11/20, the Wednesday after Resident #23's 2/7/20 significant weight loss was recorded. DON B indicated Resident #23 was not on the weight variance list brought to this SOC meeting and Resident #23 was not discussed in SOC for weight loss.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adquate tube feeding care by not providing dressing changes per the physician's orders [REDACTED].#449) out of 7 reviewed from a total sample of 20 residents resulting in delayed treatment and/or compromising the health care of the resident. Findings include: Review of the Face Sheet revealed Resident #449 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #449, with a reference date of 02/20/20 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15, which indicated Resident #449 was cognitively intact. Review of current Care Plan: for Resident #449, revised on, revealed the focus, .Nutritional/Hydration risk r/t (related to) received 100% of nutrition and hydration via peg tube . with the intervention .An ADL (Activities of Daily Living) self-care performance deficit r/t (related to) muscle wasting, low back pain, spinal fractures, hx (history) of falls with fractures . with the intervention .Tube site care/dressing as ordered . During an observation on 03/11/20 03:05 PM, Resident #449 dressing for peg tube site dated 03/07/2020. In an interview on 03/11/20 03:05 PM, Licensed Practical Nurse (LPN) S reported Resident #449's dressing on/around his peg tube is to be changed nightly. Review of General Order for Resident #449 dated 02/14/20, .Order Description: Cleanse [DEVICE] (peg tube) site with normal saline, pat dry and cover with gauze Q HS (every night at bedtime), Frequency: At bedtime, 02:00 PM -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235652	A. BUILDING _____ B. WING _____	03/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE TIMBERS OF CASS COUNTY	55432 COLBY ST DOWAGIAC, MI 49047

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 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) 10:00 PM . Review of Treatment Administration Record (TAR) for March 2020 indicated Resident #449's dressing was not changed on 03/03, 03/08, and 03/09/2020. Note: on TAR notation made for Dc'd (discontinued) on 03/10/20, no initials or notation of who wrote it. Review of General Order for Resident #449 dated 0[DATE], .DC Date: 03/14/2020 11:45 AM . Review of Treatment Administration Record (TAR) for March 2020 indicated Resident #449's dressing was not changed on 03/12 and 03/13/2020.
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** Based on observation, interview, and record review the facility failed to implement infection control standards for hand hygiene and wound care for 1 of 7 residents (Resident #7), reviewed for infection control practice, resulting in the potential for the spread of disease and infection, bacterial harborage, and worsening of wounds. Findings include: Review of a Face Sheet revealed Resident #7 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 0[DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 out of a total possible score of 15, which indicated Resident #7 was moderately cognitively impaired. Review of current Care Plan: for Resident #7, revised on 3/17/19, revealed the focus, .Has a diabetic ulcer to left foot aspect with potential for infection . with the intervention .Use pressure reduction devices for elevation of lower extremities/heels .Keep clean and dry as possible . During an observation on 03/11/20 at 10:48 AM, Licensed Practical Nurse (LPN) V while performing wound care on Resident #7 failed to perform hand washing/hand hygiene after removing her gloves when she removed the soiled dressing from Resident #7's left distal calf. LPN V proceeded to put on new gloves and cleaned the ulcer with normal saline. Once cleaned, placed Resident #7's leg directly on the Broda chair foot pressure pad without a barrier. Resident #7's foot padding was visibly soiled with streaks of brown material on the nylon covering. LPN V then proceeded to remove an ink pen from her pocket and date the bandage with today's date using her right hand. LPN V proceeded to remove the glove from her right hand and replaced it with a clean glove. LPN V did not perform hand washing/hand hygiene after removing glove. LPN V raised the resident's left leg from the foot padding with her right hand and proceeded to place the [MEDICATION NAME] and bandage on the wound using her left hand. LPN V proceeded to put Resident #7's pressuring relieving boot on his left foot without a sock. LPN V opened a swab with [MEDICATION NAME] and performed care on Resident #7's right small toe. LPN V did not perform hand washing/hand hygiene or replace gloves prior to opening the swab and beginning the treatment for [REDACTED]. LPN V once finished placed Resident #7's pressuring relieving boot on his right foot without a sock. LPN V removed her gloves, placed extra supplies back in the Treatment cart, grabbed the trash can liner with soiled items and proceeded to push Resident #7 down the hallway to the dining room. LPN V did not perform hand washing/hand hygiene after removing gloves, returning items to the Treatment cart, and prior to pushing Resident #7 to lunch in his Broda chair. In an interview with LPN V on 03/11/20 following the treatment on Resident #7's left distal calf and right small toe, she reported Resident #7's feet were placed in the pressuring relieving boots following treatment to allow his wound on his right small toe to be open to the air to promote healing. Review of Hand Washing/Hand Hygiene policy dated 10/2015 stated, .Wash hands and other skin surfaces, 4. Before and after nursing treatments or procedures (dressing changes, catheter insertion, eye drop instillation, etc.) . Review of Physician order [REDACTED].once a day .06:00 AM - 02:00 PM, ordered by Medical Doctor JJJ.