STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235520	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROMEDICA MONROE SKILLED NURSING AND REHAB	700 STEWART RD MONROE, MI 48161

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were signed and submitted to CMS (Center for Medicare and Medicaid) in a timely manner for five residents (#'s 13, 21, 24, 27, 64), resulting in a delay in monitoring of the quality of care provided to the facility's residents and identification of the facility's health concerns. Findings include: On 9/11/2020 at 11:38 AM, the MDS Coordinator, Staff C, was queried about CMS timelines for MDS submission. A review of MDS submissions was conducted with Staff C to determine compliance with CMS guidelines. According to Staff C the following submissions were submitted late: Resident #13's MDS dated [DATE] was signed on 4/7/2020 and submitted on 4/8/2020. According to Staff C, this MDS should have been signed on 3/23/2020 and submitted by 4/6/2020. Resident #21's MDS dated [DATE] was signed on 4/29/2020 and submitted on 4/29/2020. According to Staff C, this MDS should have been signed on 4/3/2020 and submitted by 4/27/2020. Resident #24's MDS dated [DATE] was signed on 4/3/2020 and submitted on 4/29/2020. According to Staff C it should have been submitted by 4/17/2020. Resident #27's MDS dated [DATE] was signed and submitted on 5/6/2020. According to Staff C it should have been signed on 4/5/2020 and submitted by 4/19/2020. Resident #64's MDS dated [DATE] was signed on 3/3/2020 and submitted on 3/3/2020. According to Staff C, this MDS should have been signed on 2/24/2020. This MDS was not signed timely. On 9/15/2020 at 10:29 AM, when the Human Resources Coordinator was queried if at any time during the year 2020 was the facility without an MDS Coordinator, she said, No. On 9/15/2020 at 11:42 AM, when the facility Administrator was queried about her expectations for the completion and submission of MDS assessments, she said, My expectation is that we follow CMS guidelines so we can be in compliance to ensure the residents are cared for appropriately and we follow the care plan processes.
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 fresh water was passed in a timely manner to two Residents (R#18 and R#24) out of three residents reviewed for hydration, resulting in the increased likelihood for dehydration, and a medically decline in the residents status. Findings include: Resident #18 On 9/9/20 at 2:45 p.m., R#18 was observed with no water cup at the bedside. On 9/10/20 at 1:00 p.m., R#18 was observed with no water cup at the bedside. On 9/10/20 at 1:03 p.m., CNA (Certified Nursing Assistant) H was interviewed. CNA H was shown that R#18 did not have a water cup at the bedside and was asked, should R#18 have water at the bedside? CNA H stated, No, because she gets thicken water Thickened Liquids give better control of the liquid in the mouth. They help slow down the flow rate of liquids, which lessens the chance of liquid going into your airway or Going down the wrong pipe. CNA H was then asked, how was the resident getting water every day. CNA H stated, I think the nurses give her water since it's thickened, she can't have it at the bedside. On 9/10/20 at 1:11 p.m., the Director of Nursing (DON) was Present on the 3rd floor unit and interviewed. The DON was asked, should R#18 have water at the bedside even if the water is thickening? The DON stated, yes, she can have it at the bedside even if it thickens. They can have thickened water at the bedside. The DON walked over to CNA H and instructed her to give R#18 a cup of thicken water at her bedside. On 9/10/20 at 1:37 p.m., CNA H was interviewed regarding the resident's care plan/Kardex (A Kardex is a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs) . CNA H was asked, where would she go to get information on the resident's care? CNA H stated, I would go to the computer on the wall and pull up the resident's name and that will show me the resident care plan. CNA H was asked to demonstrate and pull up R#18's Kardex. CNAH went to the computer on the wall which at this time she said, It's not working and attempted to demonstrate on three other computer for the CNA's to use, but all four were not working per CNA H. CNA H then attempted to use the computer for the nurses behind the Nurse station. CNA H stated, Here it is, I was able to use the nurse's computer to pull up the resident's Kardex. On 9/10/20 at 1:45 p.m., review of the resident's clinical record revealed R#18 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set ((MDS) dated [DATE] with no BIMS Score available. R#18 was not able be interviewed. R#18 required extensive assistance of one-person assistance for bed mobility, transfers, and Activities Daily Living (ADLs) and Supervision of one person for eating. On 9/10/20 at 1:53 p.m., review of the Dietary care plan initiated date 9/13/19 documented, R#18 is at risk for alteration in nutritional status relate to multiple medical conditions including dementia, dysphagia, [MEDICAL CONDITIONS] reflux disease ([MEDICAL CONDITION] reflux disease occurs when stomach acid frequently flows back into the tube connection your mouth and stomach .), hypertension, iron-deficiency [MEDICAL CONDITION], and vitamins B and C deficiencies. Interventions: Encourage and assist as needed to consume foods and/or supplements and fluids offered .Provide diet as ordered. Pureed with mildly thick liquids. Review of the ADL care plan date initiated 7/1/19 documented, Problem: Self Care Deficit related to dementia, and limited mobility, muscle weakness, and gait abnormalities. Resident #24 On 9/9/20 at 2:45 p.m., R#24 was observed with no water cup at the bedside. On 9/10/20 at 1: p.m., observed an undated cup of water on R#24's nightstand not within reach of the resident. On 9/10/20 at 1:03 p.m., during an interview, CNA H was asked, does R#24 get water at the bedside. CNA H said, Yes. CNA H was made aware of the undated water cup was and not within reach of the resident. CNA H was asked, can the reach the cup on the nightstand CNA H did not respond. CNA H also was made aware of the resident not having any water on 9/9/20 at bedside, CNA H did not respond. On 9/10/20 at 1:17 p. m., observed a cup of water on the resident's over the bed table within reach of the resident's dated 9/10/20. On 9/10/20 at 1:55 p.m., review of the resident's clinical record revealed, R#24 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the annual Minimum Data Set ((MDS) dated [DATE] with no BIMS Score available. R#24 was not able be interviewed. R#24 required extensive assistance of one-person assistance for bed mobility, transfers, and required extensive assistance of two person for dressing and toileting, and totally dependent of two people for bathing/showers. On 9/10/20 at 1:58 p.m., review of the Dietary care plan-initiated date 7/1/19 documented, Potential for altered nutrition related to advanced dementia, [MEDICAL CONDITION] .fair meal intake, and frequent refusal of lunch meals. Interventions: Encourage and assist as needed to consume foods and/or supplements and fluids offered. Review of the ADL care plan date initiated 7/1/19 documented, Focus: ADL Self Care Deficit as evidenced by requiring supervisor to moderate assistant related to dementia. On 9/10/20 at 2:10 p.m., review of the facility's policy titled Hydration Prompts date 2012 documented, Prompting patients to consume fluids and hydrate themselves is the single most effective approach in maintaining fluid balance. Patients, regardless of cognitive status, often respond to prompts to drink fluids. Depending on the individualized care plan, some patients may require more frequent and scheduled prompting. Prompting fluid intake and be paired with other scheduled interactions such as: Water in-water out-prompting to drink fluids is paired with toileting activities. Sip N go-any staff person entering a patient room while the patient is awake, offers fluids or prompts to drink. TAPS- Turn and Position, sip where fluids are offered with each position changes.

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1)
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review, the facility failed to consistently utilize the services of a Registered Nurse (RN) for eight consecutive hours per day (24 hour period), seven days a week, resulting in the potential for inadequate coordination of emergent or routine care that could cause negative outcomes, affecting the 69 residents who resided in the facility. Findings include: On 9/11/2020 beginning at 8:50 AM, an interview was conducted with Staff D who was responsible for scheduling nursing staff for the facility. A review of the daily staff postings documented the following regarding RN coverage in the building: -On 9/2/2020 we had one RN that worked two hours. -On 9/8/2020 and RN worked four hours Staff D said, if a RN worked, even a manager, I would have documented it. On 9/11/2020 beginning at 2:35 PM, an interview was conducted with the Director of Nursing (DON) regarding RN coverage in the facility. When the DON was queried if she was aware there were days when eight hours of RN services was not provided in the facility, she said, Yes. We have one full-time RN. A review of RN staffing between 8/14/2020 and 9/8/2020 was conducted with the DON and revealed the following dates when eight hours of consecutive RN services was not available: 8/14/2020, 8/31/2020, 9/1/2020, 9/2/2020, 9/3/2020, 9/7/2020, and 9/8/2020. On 9/12/2020 at 11:37 AM an interview was conducted with the facility Administrator regarding RN coverage in the building. The Administrator said, CMS (Centers for Medicare & Medicaid Services) guidelines require eight hours of RN coverage. The Administrator added that because their census is 70, the DON could not serve as the eight hours of RN (coverage). The census has to be less than 60 for the DON to be considered as the RN on duty. When queried if she was aware that there were days when the facility did not have eight hours of continuous coverage when the facility census was over 60, she said, Yes. When queried if she wanted to comment on this further, the Administrator declined. No other documents were provided by the end of the survey.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate indication or justification for use of an antipsychotic medication ([MEDICATION NAME]), failed to conduct a gradual dose reduction (GDR), and failed to monitor behaviors, or identify the underlying cause of behaviors for one (R#'s 13) of seven residents reviewed for unnecessary medications, resulting in over sedation, the potential for serious side effects, adverse reactions and inability to monitor the effectiveness of the prescribed treatment. Findings include: On 9/9/20 at approximately 11:30 AM, at 9/10/20 at approximately 9:30 AM and 2:00 PM, and 9/11/20 at 11:50 AM and 2:22 PM, R#13 was observed laying in her bed watching TV or asleep. The resident was not able to meaningfully respond verbally due to impaired cognition. The resident was not in any apparent distress, or have signs of anxiety or physical behaviors. On 9/9/20 at 12:13 PM, during a medication administration observation and review it was determined that R#13 was being administered an antipsychotic medication ([MEDICATION NAME]) since 3/4/20 as a scheduled, around the clock. Nurse J was asked why R#13 was receiving an antipsychotic medication around the clock. Nurse J replied, I don't know. Hospice ordered it. She hasn't had any behaviors in a while. According to the medical record, R#13 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The 'Significant Change' Minimum Data Set ((MDS) dated [DATE], a second Significant Change MDS dated [DATE], and the last quarterly MDS dated [DATE], identify R#13 as being 'rarely/never understood' and having 'no behaviors'. The MDS 'behavior section' E 0100 - E 0800 documented that the resident has had no hallucinations, and no behaviors of any kind. Section E 1100 indicated the resident's behavior had not changed. The resident was identified to have severe cognition impairment and be totally dependent on staff for all activities of daily living. Care plans for; 'dementia' and 'behaviors' both revised on 3/20/20 include the following interventions; attempt gradual dose reduction of antipsychotic medications, and observe and monitor for behaviors. A review of the Promedica(NAME)Skilled Nursing and Rehab Mental Health Recommendation form dated 2/20/20 recommended that there be a GDR (gradual dose reduction) to [MEDICATION NAME] once a day A review of the physician orders [REDACTED]. The SWG documented on a Mental Health Recommendation form and recommended the Physician to prescribe a continued GDR (gradual dose reduction) for an antipsychotic medication ([MEDICATION NAME]) to received one dose of [MEDICATION NAME] 0.5 mg a day. This form was signed by the physician, and indicated that he agreed with the reviewed recommendation and checked the box to please implement the above recommendation. According to the MAR (medication administration record), on 2/28/20, R#13 began receiving one dose of [MEDICATION NAME] 0.5 mg per day. There were no behaviors documented in the MDS, progress notes, or social workers notes. However, on 3/4/20, R#13 was placed on hospice services. The hospice orders included the following antipsychotic medication order: [MEDICATION NAME] 2 mg/1 ml: administer 0.5 mg = 0.25 ml per [DEVICE] every 8 hours behavioral disturbances. (mg = milligram, ml = milliliter). There is no additional [DIAGNOSES REDACTED]. On 9/10/10 at 10:34 AM, during an interview with the Director of Nursing (DON), she was asked about prolonged administration of scheduled antipsychotic medications for R#13, and to review the Hospice orders and communication records. The DON said the hospice order reads to give R#13 an antipsychotic medication around the clock, and that is what the facility nurses did. The DON could not explain why there had not been a GDR for the [MEDICATION NAME] for the last six months, or a valid [DIAGNOSES REDACTED]. The DON could not provide any documentation to indicate there was any communication or coordination between hospice and facility staff regarding the continued use of an antipsychotic medication. There were no resident behavior logs, or other documentation to indicate the resident was being monitored for side effects of antipsychotic medications. The DON said that residents do not get followed by (SWG) psych services when they are on hospice. The DON said that the facility's social workers follow the residents that are prescribed antipsychotic medications. During an interview with the Social Work Director on 9/10/20 at 11:03 AM she said there were no behavioral logs for R#13. The Social Work Director said she was aware that R#13 had been receiving an antipsychotic medication ([MEDICATION NAME]) as a scheduled around the clock medication, but that she (R#13) was being followed by hospice. A review of R#13's Pharmacy Monthly Medication Review from 3/20 through 8/20 revealed there were no recommendations by the pharmacist to initiate a GDR for the antipsychotic medication, ([MEDICATION NAME]). Even though the resident had a successful GDR of [MEDICATION NAME] back in February of 2020. During a telephone interview with the Pharmacist on 9/10/20 at 12:51 PM, she said that the R#13 had failed her GDR back in February and she would not be required to re-try a GDR for another year. The Pharmacist could not provide any explanation or documentation to indicate why she thought R#13 had failed her GDR of [MEDICATION NAME] in February of 2020. The Pharmacist did say that she had not conducted in-house visits since Covid-19 visitation restrictions, and had been doing everything electronically. During a telephone interview with R#13's Hospice nurse (nurseI) on 9/10/20 at 1:34 PM he was asked to review what medications R#13 was receiving. Nurse I reported that R#13 was receiving [MEDICATION NAME] PRN (as needed). Nurse I was unaware that R#13 had been receiving a scheduled antipsychotic medication three times a day, every day since 3/4/20. Nurse I said, I've only been R#13's nurse for a few weeks and did not know what medications she was on. I don't look at the actual Medication Administration Record [REDACTED]. No wonder she (R#13) has been so out of it. They've got her 'snowed'. I will get this changed immediately. According to the facility's 'Antipsychotic Drug Monitoring' policy updated on 4/2018; Criteria for Antipsychotic drug use: Antipsychotic drug therapy shall only be used when it is necessary to treat a specific condition. - Unless the resident's medical record clearly indicates that the resident has one or more of the following 'specific conditions' antipsychotic drugs should not be used. These include: [MEDICAL CONDITION], schizo-affective disorder, delusional disorder, psychotic mood disorder, [MEDICAL CONDITION], schizophreniform disorder, [MEDICAL CONDITION]'s disorder, [MEDICAL CONDITION]'s disease, nausea/vomiting associated [MEDICAL CONDITION] or chemo, or organic mental syndromes. -preventable causes of behavior have been ruled out -behavioral interventions have been attempted and have been documented via the behavior management program, nursing notes or social worker notes to be inadequate or unresolved. - the behavior presents a danger to the resident or others or is a source of severe distress or dysfunction for the resident and the symptoms are identified as being due

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) [MEDICAL CONDITIONS]. - Gradual Dose Reduction and re-evaluations are provided. Procedure: 9) GDRs will be attempted at least one time every six months after antipsychotic therapy has begun.
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.** Based on observation, interview, and record review the facility failed to maintain sanitary food contact and non-contact surfaces resulting in potential cross contamination. This deficient practice affects all 69 residents in the facility. Findings include: During the initial kitchen tour on 09/09/2020 at 09:00 AM the following was observed: 1. Exterior of the dish machine heavily soiled with black residue and white mineral deposits. When queried, Certified Dietary Manager (CDM) A advised they are in the process of getting a new one. During review of the facility's Maintenance of Dish Machine policy, it stated Procedure: 1. The dish machine will be regularly cleaned and de-limed as needed. According to the 2013 FDA Food Code Section 4-501.14(NAME)washing Equipment, Cleaning Frequency. A WAREWASHING machine; the compartments of sinks, basins, or other receptacles used for washing and rinsing EQUIPMENT, UTENSILS, or raw FOODS, or laundering wiping cloths; and drainboards or other EQUIPMENT used to substitute for drainboards as specified under 4-301.13 shall be cleaned: (A) Before use; (B) Throughout the day at a frequency necessary to prevent recontamination of EQUIPMENT and UTENSILS and to ensure that the EQUIPMENT performs its intended function; and (C) If used, at least every 24 hours. 2. Food debris and grease deposits in the 1st floor microwave. CDM A advised the dietary staff are responsible for cleaning out the microwave. During review of the facility's Cleaning Instructions: Microwave Oven policy, it stated Policy: The microwave oven will be kept clean, sanitized, and odor free. According to the 2013 FDA Food Code, 4-602.12 Cooking and Baking Equipment. . (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 3. Food debris in the microwave, dry red liquid in the freezer, and dry yellow liquid in the refrigerator on the 2nd floor. During review of the facility's Cleaning Instructions: Refrigerators policy, it stated Policy: The refrigerators will be washed thoroughly inside and outside with a detergent and followed by a sanitizer at least once every month, or as needed. Spills and leaks will be wiped up as they are noticed. According to the 2013 FDA Food Code, 6-501.12 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. 4. Dry red liquid inside the 3rd floor refrigerator.