STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235372	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE BAY AT CRANBROOK HEALTH & REHABILITATION CTR	5000 E SEVEN MILE RD DETROIT, MI 48234

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 0684 **Level of harm -** Immediate jeopardy **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 number MI 922. Based on interview and record review the facility failed to assess and monitor for a change in condition and notify the physician for one (R#1) of five sampled resident's, (R#1) with known cardiovascular and chronic liver failure conditions by not obtaining a baseline or daily weight from 6/11/20 to 6/19/20 resulting in hospitalization for unconsciousness, grossly [MEDICAL CONDITION] (swollen with excessive accumulation of fluid) and anasarca (swelling throughout the body). As a result of failing to monitor residents' weight from 6/11/20 to 6/19/20 (8 days) or notify physician of change of condition, lead to gross generalized [MEDICAL CONDITION] causing a loss of airway reflexes (airway [MEDICAL CONDITION]), requiring endotracheal intubation (placing a flexible plastic tube into the trachea to maintain an open airway). The Immediate Jeopardy (IJ) was identified on 7/16/20 at 2:50 p.m., as a result of failure to assess and monitor for change in condition and notify the physician for R#1 leading to hospitalization and the likelihood of other resident affected due to lack of assessment, monitoring and physician notification practices that could lead to serious harm, injury, impairment or death. The Administrator was notified of the Immediate Jeopardy (IJ) on 7/16/20 at 2:50 p.m. The Immediate Jeopardy began on 6/11/20. A plan to remove the immediacy was requested. The IJ was removed on 7/17/20, based on the facility's implantations of the plan of removal as verified by the Surveyor on site. Although the IJ was removed, the facility's deficient practice was not corrected and remained isolated with actual harm. Findings Include: Review of a complaint dated 6/19/20 called into the State Agency documented, . Emergency Medical Service (EMS) reported that (name of facility) had believed patient to be sleeping earlier this morning however, upon further examination a few hours later they determined that (name of R#1) was not able to be aroused. Medical record review revealed that R#1 was admitted into the facility on [DATE] with cardiovascular and chronic liver failure conditions including high blood pressure, stroke, ascites (accumulation of fluid in the abdominal cavity), hepatic [MEDICAL CONDITION] (liver disease) and burn to left lower leg. The Admission Minimum Data Set Assessment ((MDS) dated [DATE] indicated the resident cognition was moderately impaired, and required extensive assistance from staff for all activities of daily living. Review of the hospital discharge orders dated 6/11/20 documented, remember to weigh yourself at the same time everyday, and call your doctor's office for the following symptoms: -If your have weight gain-more that 2 pounds since yesterday or 5 pounds this week -If your have increased swelling in your ankles, legs or stomach/abdomen . Upon further review of the resident's clinical record there was no documented baseline or daily weights from admission on 6/11/20 to discharge on 6/19/20 (a total of 8 days) for R#1. Review of R#1's blood pressure readings documented exceeded high blood pressures (normal b/p 120/80): - 6/11/20 - 175/102 millimeters of mercury (mmHg); - 6/12/20 - 150/90 mmHg; and - 6/18/20 (the day prior to the resident being sent out to the hospital) - 177/111 mmHg, with out documented evidence of physician notification in change in condition. Review of the clinical progress notes revealed for the 8 days of the resident stay at the facility, there was no admission nurses note summarizing the resident admission into the facility. No physician's progress note or history and physical. Only a nursing progress note dated 6/12/20, a social service note dated 6/16/20 and discharge nursing progress note dated 6/19/20 (a total of 3 notes for an 8 day stay). Review of the clinical initial assessments revealed the following: -6/11/20 admission assessment - In progress (incomplete) -6/12/20 nutritional assessment - In progress (incomplete) -6/12/20 catheter assessment- In progress (incomplete). At 10:30 a.m., Unit Manager Nurse B said, The Admission Nursing assessment dated [DATE], was not performed until 6/12/20 (the day after the residents admission), I saw that the Admission Assessment had not been completed, so I did it myself the next day. We had inconsistent (nurse) staffing here at that time. The assessments should completed by the admitting nurse, not left incomplete. At 12:06 p.m., the facility's Director of Nursing (DON) was interviewed regarding the facility's policy on obtaining baseline assessments (including weights), documentation and physician notification. The DON said that when a patient is admitted into the facility a skilled daily nursing assessment per shift is completed and documented on for the first 5 days. She said the nurse should do the admission nursing assessment and call the physician to verify the admission orders [REDACTED]. The DON said that the nutritional assessment dated [DATE] and the 6/17/20 Admission MDS documented a weight. Upon further investigation the weight that was used for these documents was a hospital weight which was obtained on 6/3/20 (8 days prior to admission into the facility). On 7/17/20 at 12:20 p.m., during an interview with the Dietician she said the facility should obtain a baseline weight upon admission and weekly after that until the weights are stable. Review of the hospital emergency room records dated 6/19/20 documented, (age/sex of resident) presents from the nursing facility via EMS with altered mental status. Onset unknown. Per the nursing home, they do not know what medical problems (resident) has, only that (resident) takes (name of blood thinner medication) for some reason. They did not provide paperwork that contains any information about the patient's history .blood pressure as 158/102 .patient appears grossly [MEDICAL CONDITION] in no acute distress. He is unresponsive. He has no gag reflex .anasarca is demonstrated and there is [MEDICAL CONDITION] al all 4 extremities that is pitting .loss of airway reflexes, requiring endotracheal intubation for airway protection. Review of the facility policy document titled, Change in Residents Condition or Status dated 7/2019 documented, Policy Interpretation and Implementation 1. The nurse will notify the resident ' s Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident ' s physical/emotional/mental condition; e. need to alter the resident ' s medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the Physician of changes in the resident ' s condition . 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. Review of the 2006 Assessment and Care Plan policy documented, ASSESSMENTS: NURSING Resident Nursing Assessments (name of facility) Health Care Facilities conduct and document comprehensive assessments of residents in accordance with the state approved MDS process. Assessments are initiated upon admission and must be completed within 14 days from date of admission, quarterly and yearly thereafter. If there is a change in condition a new assessment must be initiated'. IJ Removal Plan: Change in Condition: 1. R1 no longer resides in the facility. The R1 was originally admitted to the facility with the following [DIAGNOSES REDACTED]. R1 became unresponsive and was transferred out to a local hospital. R 1 was unable to protect airway resulting in intubation consequently transferred to hospice service while at the hospital. 2. The Director of Nursing, Assistant Director of Nursing, QA Nurse (RN), MDS Coordinator RN and a RN Charge Nurse completed nursing assessment on all 30 residents and documented the result on a (monthly nursing assessment) form. The assessment form includes mobility status, transfers, positioning, Grooming, cognitive status, emotional/behavioral concern, skin condition, bowel & bladder,

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** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) eating habits, sleep pattern, pain management, and vital signs with a current weight. After review of the monthly assessments form, one change in condition was identified, An Interact Change of condition form was completed, included in the interact was notification of physician and responsible party. All 30 July resident's weights were completed and verified by Director of Nursing. All 30 resident's vital signs have been obtained and reviewed; no deviations were noted. deviation from baseline or abnormal ranges the physician and responsible party were notified. All 30 resident's Care plans were reviewed and updated as appropriate. 3. Change in Condition policy has been reviewed and updated to include notification of the Director of Nursing of any changes, as well as physician and responsible party. The weight policy will include admission weight & weekly weights times four until stable. Unit Managers to audit the resident's clinical record within 72 hours after admission to verify weights & vital sign completed and required assessments are completed. If the &72-hour audit notes incomplete nursing assessments, the responsible nurse will be called to complete the assessment, or the Nurse manager or designee will complete a new assessment. Nursing staff were in-serviced regarding completing assessments and Change in condition policy, 3 of 4 Licensed Practical Nurses were in-serviced on 6/16/20 4 of 4 Registered Nurses were in-serviced 6/16/20 4 of 14 Certified Nursing assistants were in-service NO Nursing staff will be allowed to work without receiving in-service. A newly hired MDS Coordinator registered nurse was added to the team to ensure completion and accuracy of assessments and care plans. The Director of clinical will complete weekly X four then forward site visits to ensure compliance. 4. The Director of Nursing/Designee will audit the 24-hour communication board 5 times per week times four weeks to identify any changes in condition including changes. The Director will follow up any alerts. Unit managers/designee will audit all admissions within 72 hours of admission to ensure a complete nursing assessment including baseline weight obtained by the facility was completed. The audit will include weight changes, falls, mental, skin changes physical changes. If any assessment is identified to be in progress , the responsible team member will be notified for competition. The results of the 24-hour communication audit will include, change in condition, weight audits will be forwarded to the QAPI team for further evaluation. 5. The Director of Nursing is responsible for maintaining compliance.
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** This citation pertains to Intake number MI 922. Based on interview and record review the facility failed to ensure wound care was provided for one sampled resident (R#1) from total sample of five, resulting in the potential for worsening or infection of the wound. Findings include: Review of a complaint filed with the State Agency dated 6/19/20 from a local hospital documented, .(Name of R#1) emergency room physician noted that (name of R#1) had sacral ulcers that were stages 2-3 (partial thickness loss of skin presenting as a shallow open ulcer with a red wound bed) and undressed upon arrival. emergency room physician remarked that the wounds being undressed indicates that the nursing staff at the facility was either not turning (name of R#1) and that was how ulcers formed, or (name of R#1) arrived with ulcers starting to form, and facility did not notice or treat . Review of the hospital discharge paperwork dated 6/11/20 revealed; -(name of resident) was brought to emergency department status [REDACTED]. Workup revealed the 12% burn to the left lower leg . -a physician's orders [REDACTED]. Medical record review revealed that R#1 was admitted into the facility on [DATE] with cardiovascular and chronic liver failure conditions including high blood pressure, stroke, ascites (accumulation of fluid in the abdominal cavity), hepatic [MEDICAL CONDITION] (liver disease) and burn to left lower leg. The Admission Minimum Data Set Assessment ((MDS) dated [DATE] indicated the resident cognition was moderately impaired, and required extensive assistance from staff for all activities of daily living. At 10:30 a.m., Unit Manager Nurse B said, The Admission Nursing assessment dated [DATE], was not performed until 6/12/20 (the day after the residents admission), per the assessment R#1 had a wound on his sacrum (area at the base of the lumbar vertebrae) and left lower leg. A physician's orders [REDACTED]. Review of the treatment administration records (TAR's) for June 2020 revealed that the treatment was done 2 times (6/12/20 and 6/18/20) in the 8 days that the resident resided in the facility. There was no treatment order for the sacrum wound. There was no documentation that the facility staff provided daily showers. At 12:06 p.m., the facility's Director of Nursing (DON) was asked about the wound care for R#1. The DON said that the admitting nurse should have obtained an treatment order for the sacral wound. The DON said during that time the facility had supplemental staff coming in from sister facilities (facility's owned by the same company), That may have been why the treatments were not provided. Review of the facility's policy titled Medication and Treatment Orders dated January 2017 documented, Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. , 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 3. Drug and biological orders must be recorded on the physician's order [REDACTED]. Such orders are reviewed by the consultant pharmacist on a monthly basis. 4. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake number MI 922. Based on interview and record review the facility failed to maintain a complete and accurate medical record for one sampled resident (R#1) from a total sample of five, resulting in the potential for mismanagement or unmet care needs. Findings include: Review of a complaint filed with the State Agency dated 6/19/20 from a local hospital documented, .Emergency Medical System (EMS) reported that the (name of facility) staff did not know (name of R#1) medical history, despite (name of R#1) being at facility for 8 days. Medical record review revealed that R#1 was admitted into the facility on [DATE] with cardiovascular and chronic liver failure conditions including high blood pressure, stroke, ascites (accumulation of fluid in the abdominal cavity), hepatic [MEDICAL CONDITION] (liver disease) and burn to left lower leg. The Admission Minimum Data Set Assessment ((MDS) dated [DATE] indicated the resident cognition was moderately impaired, and required extensive assistance from staff for all activities of daily living. Review of the clinical progress notes revealed for the 8 days of the resident stay at the facility, there was no admission nurses note summarizing the resident admission into the facility. No physician's progress note or history and physical. Only a nursing progress note dated 6/12/20, a social service note dated 6/16/20 and discharge nursing progress note dated 6/19/20 (a total of 3 notes for an 8 day stay). Review of the clinical initial assessments revealed the following: -6/11/20 admission assessment - In progress (incomplete) -6/12/20 nutritional assessment - In progress (incomplete) -6/12/20 catheter assessment- In progress (incomplete). At 12:06 p.m., the facility's Director of Nursing (DON) was interviewed regarding the facility's policy on obtaining baseline assessments (including weights), documentation and physician notification. The DON said that when a patient is admitted into the facility a skilled daily nursing assessment per shift is completed and documented on for the first 5 days. She said the nurse should do the admission nursing assessment and call the physician to verify the admission orders [REDACTED]. Review of the facility's policy titled, Order of Record Assembling dated 12/2006 documented, The resident ' s medical records shall be assembled in a systematic order. 1. Assembling the medical record for disposition is completed at the time of discharge or death of the resident. 2. The Medical Records Clerk shall be responsible for properly arranging the medical record for final disposition. 3. The following order of arrangement, as it may apply, has been adopted by our facility in arranging medical records for final disposition: a. Advance Directives (as applicable); b. Identification and summary record; c. Resident Assessment (MDS); d. Admission agreement; e. Medical history and physical examination [REDACTED]. Lab reports; h. X-ray reports; i. Electrocardiographs; j. Progress notes; k. physician's order [REDACTED]. Graphic charts; n. Nurses ' notes; and o. Others as necessary or appropriate. 4. All medical records will be reviewed by the Medical Records Consultant and a written report shall be filed with the Administrator as outlined in the consultant ' s agreement.