STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON AIRE HEALTHCARE CENTER	17001 17 MILE RD CLINTON TOWNSHIP, MI 48038

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F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** Based on interview and record review, the facility failed to complete the discharge Minimum Data Set (MDS) assessments for two residents (R1 and R2), resulting in an inaccurate reflection of the residents' status. Findings include: On 9/23/20 at 9:55 AM, during record review, R1 was noted to have been discharged from the facility with the following progress note: 6/13/2020 12:30, Nursing Note .Resident discharged home .Discharge instructions and prescriptions given to resident .Resident took all personal belongings .Resident states understanding of all instructions . Upon review of R1's MDS assessments, a discharge MDS assessment was not noted to be in progress or submitted for R1. On 9/23/20 at 9:56 AM, during record review, R2 was noted to have been discharged from the facility with the following progress note: 6/13/2020 10:56 Discharge Note .Patient discharged .Discharge instructions and prescriptions reviewed and sent with patient, signed copy placed in patient's chart. Patient observed transferring in car, vital signs within normal limits. Family instructed to call with any questions or concerns. Upon review of R2's MDS assessments, a discharge MDS assessment was not noted to be in progress or submitted for R2. On 9/24/20 at 10:12 AM, MDS Coordinator Nurse N was interviewed and asked to review the MDS assessments for R1 and R2. When asked if the residents should have had a discharge MDS assessment submitted, Nurse N stated, Yes. No further explanation was provided. When queried regarding a policy/procedure for MDS submissions, Nurse N stated, We follow the RAI (Resident Assessment Instrument). The CMS RAI Manual 3.0 indicates the discharge MDS assessment completion date should be no later than the discharge date plus 14 calendar days, and the transmission date no later than the MDS completion date plus 14 calendar days.
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 routine activities of daily living and consistent documentation for three sampled residents (#45, #62, and #80) of four reviewed for activities of daily living, resulting in overgrown facial hair, missed showers, and unkempt hair. Findings include: Resident #45 On 9/22/20 at 8:59 AM, Resident #45 (R45) was observed in their room laying in bed. Resident #45 was unable to be interviewed due to a cognitive impairment. It was reported that Resident #45 had not had a shower in a long time and their days were Tuesday and Friday. On 9/23/20 at 2:40 PM, it was reported by R45's roommate that R45 did not received their shower yesterday (Tuesday 9/22/20). R45 was observed sitting in bed with uncombed hair. On 9/23/20 at 3:02 PM, Unit 2 Manager (Nurse Z), was asked for documentation for R45's showers. A review of (R45's) shower/bathing record from the 9/9/20 to present noted, 9/9/20 physical help limited to transfer only, 9/11/20 Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity, 9/15/20 physical help limited to transfer only, 9/19/20 independent - no help provided, 9/20/20 total dependence, 9/22/20 physical help in part of bathing activity, and 9/23/20 none documented. On 9/24/20 at 9:50 AM, Nurse Z was asked about the documentation and the assistance required for R45's showers. Nurse Z stated, There are some inconsistences in charting. Nurse Z was asked to review the documentation that noted, independent and was asked if R45 was able to be independent in showers. Nurse Z stated, No (R45) is not. A review of R45's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that R45 was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively impaired and required total assistance from two staff for bathing and personal hygiene. Resident #62 On 9/22/20 at 9:32 AM, Resident #62 (R62) was observed in bed sleeping with some of their hair standing up and braided. Resident #62's feet were exposed and appeared dry and with flakes of skin from feet on bedding. On 9/24/20 at 1:39 PM, Resident #62 was observed with their hair in the same manner as on 9/22/20. On 9/24/20 at 2:27 PM, the Director of Nursing (DON) was asked the facility's expectation regarding activities of daily living for residents. The DON explained that it's part of the daily routine and preference. On 9/24/20 at 3:00 PM, Resident #62 (R62) was observed with four braids in the back of their hair. Certified Nursing Assistant (CNA M) confirmed that she had not put them in. CNA M was observed to touch the back of R62's hair. R62's hair and braids were observed to be matted (tangled into a thick mass.). A review of R62's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that R62 was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively impaired and required assistance from staff for bathing and personal hygiene. Resident #80 On 9/22/20 at 8:30 AM, Resident #80 (R80) was observed in bed with thick chin hairs observed on both sides of R80's chin and their hair appeared greasy and had a ponytail at the top of their head. R80 was asked about showers and hair washes and stated, When they get around to a bed bath. They haven't tried to wash hair. They are always in a hurry and complaining and I will maybe get five minutes of their time. On 9/23/20 at 12:59 PM, R80 was observed in bed sleeping, chin hairs and hair in the same condition as 9/22. On 9/24/20 at 1:16 PM, CNA M was asked about R80's chin hair and stated, Yes I saw that today and will be taking care of it. I wasn't with (R80) yesterday, but I will be taking care of that today. A review of R80's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that R80 was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively impaired and required assistance from staff for bathing and personal hygiene. A review of the facility's policy titled, Routine Resident Care dated September 2011, noted, Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene. Steps are taken to ensure that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to ensure resident safety at all times . 2. Showers, tub baths, and/or shampoos are scheduled at least twice weekly and more often as needed. Bed linens are changed at this time. 3. Daily personal hygiene minimally includes assisting or encouraging residents with washing their faces and hands, combing their hair each morning, and brushing their teeth and/or providing denture care .
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** Based on interview and record review, the facility failed to initiate CPR (Cardiopulmonary Resuscitation) on a resident (R111) who was a full code. This deficient practice resulted in an Immediate Jeopardy when staff found the resident to be unresponsive and pronounced the resident dead on [DATE] at 10:35 PM without attempting life-saving measures per the resident's documented wishes. The Immediate Jeopardy (IJ) started on [DATE] and was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] and was asked for a plan to remove the immediacy. The IJ was removed on

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

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) [DATE], based on the facility's implementation of the removal plan as verified onsite on [DATE]. Although the immediacy was removed the facility's deficient practice remained isolated with actual harm that is not immediate jeopardy. Findings include: A review of R111's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that the resident was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively impaired and required extensive assistance from staff for activities of daily living (ADLs), mobility, and transfers. The resident was noted to be marked on the MDS as receiving hospice services while in the facility. Further review of R111's electronic medical record revealed that the code status (whether the resident wished for live-saving measures, such as CPR) for the resident on the main screen was listed as a Full Code. A review of R111's facesheet also noted, ADC: Full Code. Review of the resident's physician orders [REDACTED]. Active [DATE]. Additional review of documentation in R111's hard copy chart and electronic medical record revealed the following advance directive document titled, Life-Sustaining Treatment, signed and dated [DATE]th, 2020 (uploaded into the electronic medical record on [DATE]), which read: Some people do not wish to have certain life sustaining treatments under any circumstance, even if a recovery is a possibility. With each treatment listed below, please indicate either yes or no. Yes means that you agree to and want to have this treatment. Or No, that you do not wish to have this treatment under any circumstances. Cardiopulmonary Resuscitation (CPR): Yes Ventilation (breathing machine): No Feeding tube: No [MEDICAL TREATMENT]: Yes Blood Transfusion: Yes This will provide peace of mind to be able to choose healthcare decisions when you no longer can communicate your wishes. Further review of R111's medical record revealed the following progress notes: [DATE] 19:42 (7:42 PM) Provider Note, Encounter Date: [DATE], Chief Complaint: Initial visit .Per discussion with family as interpreters for patient patient does not wish for intubation however does wish for CPR. Discussed with hospice team CODE STATUS will need to be further discussed with family if patient is to remain on hospice care .Code Status: Full code with no intubation. [DATE] 18:58 (6:58 PM) Social Services Note, Note Text: resident (family) provided Patient Advocate forms for resident chart today, scanned and uploaded, resident (family) continues to visit daily through window .brought resident some snacks, writer asked if full code status to remain with hospice care resident (family) responded yes full code to remain in place. Effective Date: [DATE] 22:35 (10:35 PM) Type: Nursing Note Resident expired [DATE] at 10:35 pm. Family and hospice notified. Remains picked up by (Funeral Home). Author: (LPN F) - Licensed Nurse (e-SIGNED). Effective Date: [DATE] 22:38 (10:38 PM) Type: Nursing Note Resident expired at 10:35 p. Resident observed for heart and lung sounds; no heart or lung sounds observed at that time. Physician and hospice notified. Author: (RN E) - Registered Nurse (e-SIGNED). Effective Date: [DATE] 17:16 (5:16 PM) Type: Discharge Note, Note Text: .Encounter Date: [DATE], Code Status: Full code with no intubation, Disposition: Patient expired [DATE]:35 PM .Per discussion with family as interpreters for patient patient does not wish for intubation however does wish for CPR. Discussed with hospice team CODE STATUS will need to be further discussed with family if patient is to remain on hospice care . The note did not mention administration of CPR on the day R111 expired. No additional progress notes dated [DATE] were present in R111's record along with no progress notes dated [DATE] or [DATE]. The following vital signs were noted in R111's medical record, entered by LPN F: (Blood pressure) [DATE] 20:44 (8:44 PM): 115 / 78 mmHg Lying r/arm (right arm). (Pulse) [DATE] 20:44 (8:44 PM): 108 bpm (beats per minute). (Temperature) [DATE] 20:44 (8:44 PM): 98.5 F Oral. (Oxygen Saturation) [DATE] 20:44 (8:44 PM): 96.0 % Room Air. The most recent set of vital signs prior to [DATE] on R111 were noted to be taken last on [DATE]. On [DATE] at 3:50 PM, Registered Nurse (RN) E was interviewed regarding their note entered into R111's record on [DATE]. RN E stated, I was working station 1. (LPN F) came down and asked me to pronounce the resident (deceased). I went to see (R111) with my stethoscope in hand, I did not see breathing or pulse, the resident was pale with mucus coming out of their mouth. Their arms were still a little warm, hands were cool. I assessed hardened lung sounds and pronounced (R111) at the time I wrote in my note. (LPN F) notified hospice and the family. I had to talk to the family about the policy and procedure regarding seeing the resident. Prior to that, (LPN F) had informed me (R111) was a full code. That was about 20 minutes after the fact that I had pronounced (them deceased). When asked who saw the resident initially, RN E stated, (LPN F). (LPN F) didn't mention anything about the resident other than I needed to pronounce them. When queried if they would have done CPR if they had known the resident's code status, RN E stated, If it seemed like (R111) had recently passed and I knew (their) code status then yes. On [DATE] at 3:55 PM, an attempt to interview LPN F via phone call was made. A voicemail was left for call back. On [DATE] at 3:57 PM, an attempt to interview Resident Care Aide (RCA) G via phone call was made. A voicemail was left for call back. On [DATE] at 5:05 PM, the Director of Nursing (DON) was queried what the expectation of staff is if a resident is listed as a full code and replied, The expectation of staff if listed as a full code and attempt CPR is for staff to perform or attempt to perform (CPR) if (the resident) is found unresponsive. When queried if staff is expected to follow resident advance directives, the DON stated, My expectation is for staff to follow advance directives. When queried if advance directives through hospice and through the facility were the same, the DON stated, Hospice and our advance directives are combined. When queried regarding R111's advance directive, the DON confirmed that the facility's advance directive on file for R111 dated [DATE] was what was to be followed. When queried regarding R111 passing away in the facility on [DATE], the DON stated, I asked the nurses who were on that night what happened and they gave their statements and gave them to me. On [DATE] at 5:26 PM, a second attempt to interview LPN F via phone call was made. A voicemail was left for call back. On [DATE] at 8:55 AM, LPN F was interviewed via phone call. When queried regarding what happened before and during R111's passing away in the facility on [DATE], LPN F stated, I was in another room, passing meds. Came on shift, started at 7 PM. An hour or two later the aide had called me, (R111) was receiving [MEDICATION NAME] every 2 hours. I had given [MEDICATION NAME] for that timeframe. When queried if that was why they had documented vital signs on the resident on [DATE] at 8:44 PM, LPN F stated, I believe so, I might have given it a little sooner. I gave [MEDICATION NAME] and was in another room on the east side, (R111) was on the west side. The aide came and called me and told me it looks like the resident was gone and the resident wasn't doing anything. I yelled for help from my co-worker. I assessed (R111) didn't have a pulse, did sternal rub. Looked like (they were) completely gone. Not sure how long. Then my coworker was in the room we checked there was no pulse. Not sure how long (R111 was gone). I called the RN (RN E) that was there, the RN confirmed (R111) passed. When asked if they were aware of R111's code status, LPN F stated, I thought (R111) was a DNR (do not resuscitate). When asked if they had seen the code status after the resident had been pronounced as deceased , LPN F stated, Yes. Not like hours after, but yes. When asked if the aide knew if the resident was a full code, LPN F stated, The aide wouldn't know that. I don't think they would know that I'm not sure. When asked the name of the aide, LPN F indicated that it was RCA G. On [DATE] at 9:11 AM, a second attempt to interview Resident Care Aide (RCA) G via phone call was made. A voicemail was left for call back. No call back from RCA G was received prior to survey exit. On [DATE] at 9:15 AM, LPN F called back and stated they wanted to add a piece of information. LPN F stated, Vital signs - I took them at the time (I found R111) but didn't get numbers. When asked if they documented that, LPN F stated, Yes I think in the progress note. Upon review of the progress note, no information related to vital signs was found. The only set of vital signs recorded for R111 on [DATE] were entered by LPN F at 8:44 PM. On [DATE] at 9:30 AM, LPN J was asked where nurses check for code status in the medical record. LPN J stated, In PCC (electronic medical record) right on the face page or look in the paper chart. And it's in the physician orders. When queried what the procedure is if a resident is found unresponsive, LPN J stated, If full code, start CPR and if DNR, make comfortable. But a full code, definitely CPR. When asked if they checked code status for hospice residents, LPN J stated, I will check because we have had residents here who were hospice who have been full code or request that CPR be done. On [DATE] at 9:41 AM, Social Worker (SW) H was interviewed regarding R111's code status. SW H stated, When (R111) first came in, (there was discussion regarding the resident) being a full code but their culture doesn't allow them to do DNR. So, (R111) came in on hospice and was a full code. They had no POA (Power of Attorney) but because there was no POA, (the resident) was a full code. There was a language barrier. I asked the (family member) to translate how the resident felt. The (family member) was outside the window for a conversation with the resident .and asked the resident, 'Do you want CPR?' (R111) nodded their head (yes), asked 'Do you want to be DNR?' (R111) gestured no. (The resident) talked with family when they came, the resident trusted them and I trusted those were (R111's) wishes based on the family. It was a collaborative effort to determine the resident's wishes. I can't push people on what to do, I have to be on the side of the resident and their wishes, and (R111's) wish was full code. When queried regarding education given on following advance directives, SW H stated, Yes. We did a full audit. Made sure everyone understands the location of (the advance directive). As a nurse or anyone you can't just assume (code status), you need to be careful and look at everything. We did every code status in the system 100%, we are becoming [MEDICATION NAME]. Everyone was educated, (aides) are required to know and they should. We educate everyone to know the process. A review of the facility's policy/procedure titled, Medical Emergency Management, revised February 2017, revealed: The facility ensures residents receive timely and appropriate interventions in

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) the event of a medical emergency. The staff takes actions to ensure that the resident's airway, breathing, and circulation are maintained until emergency personnel arrive. Staff is aware of each resident's physician orders [REDACTED].Once a medical emergency is identified, qualified staff assesses the resident, initiates the appropriate emergency procedure(s) in accordance with physician's orders [REDACTED]. The staff continues to provide care and monitor the resident until the emergency personnel arrive. A review of the facility's policy/procedure titled, Advance Directives, Revision Date: February 2017, revealed: The resident has a right to accept or refuse medical or surgical treatment and to formulate an advance directive in accordance with State and Federal law. The facility uses its best efforts to comply with the wishes of a resident as expressed in an advance directive and will not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive .3. If a resident has executed an advance directive the facility must obtain a copy from the resident or the legal representative which is stored in the resident's medical record file. Nursing notifies the physician of the resident's or the legal representative's wishes, obtains orders as appropriate, and enters the information in the Electronic Health Record .7. The facility's copy of the advance directive must be filed in the resident's clinical record .1. Copies of any advance directives are maintained in the resident's clinical record. 2. The facility must document in a prominent part of the resident's clinical record whether the resident has issued an advance directive. F678 Immediate Jeopardy - Plan for Removal The preliminary fact analysis demonstrates that the facility failed to initiate CPR on a resident who was a full code. The resident was pronounced dead on [DATE] at 10:35 PM without initiation of CPR or notification of 911. -Resident (R111) expired on [DATE] while receiving hospice services. -DON interviewed staff involved and provided immediate education to RN and LPN involved on [DATE]. -Interdisciplinary team meeting held [DATE] to review all current advance directives. Facility leadership educated on Advance Directive policy. -The Medical Director was notified of the failure to initiate CPR [DATE] and of Immediate Jeopardy on [DATE]. -All residents that are residing in the facility with a full code status have the potential to be affected in a similar manner. -A facility audit was completed on [DATE] to ensure appropriate code status orders for all residents who currently reside in the facility. -Education with specific focus on acquiring and following advanced directives including initiating CPR and notifying 911 for all licensed staff has been initiated and will be completed prior to the start of their next shift. The Administrator is responsible for attaining and maintaining compliance. Completion date: [DATE].
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 ensure residents are repositioned timely for two sampled residents (R71 and R162) of five reviewed for pressure sores, resulting in the potential for delayed wound healing or worsening of a wound. Findings include: Resident #71 On 9/22/20 at 1:35 PM, R71 was observed to be in bed laying on their back, heels up, and boots on. R71 did not respond to questions. Per the Minimum Data Set (MDS) assessment date 08/04/20, R71 had impaired cognition and the need for extensive assistance of one for bed mobility. On 9/22/20 at 1:54 PM, R71 was observed to be in bed with the head of the bed up approximately 45-60 degrees, head turned to face the right side. The resident was resting on their buttocks without positioning devices along the sides to offload pressure. On 9/23/20 at 8:43 AM and 10:52 AM, R71 was observed seated on their buttocks in bed, heel boots on, and the head of the bed up approximately 45-60 degrees. The resident's head was down and turned to face the right shoulder. On 9/23/20 at 11:14 AM, a Hospice nurse visited R71 and was returned to the upright position in bed. On 9/23/20 at 1:07 PM, R71 was observed to be seated in a similar position as before with the head of the bed around 45-60 degrees, hunched over slightly and leaned more toward the right side. R71's eyes were open, but R71 did not respond to questions. On 9/23/20 at 3:31 PM, R71 appeared in the same position as before, but was asking for a drink of water and complained that they had been in bed all day. A review of the facility records for R71 revealed an admission into the facility on [DATE] and [DIAGNOSES REDACTED]. A review of the MDS assessment dated [DATE] indicated moderately impaired cognition and the need for extensive assist of one person for bed mobility and was a two person assist for transfer. The pressure ulcer care plan intervention dated 09/01/20 indicated, Encourage/assist to reposition and or turn frequently for pressure relief. A Skin-Weekly Pressure Ulcer Record date 09/18/20 revealed R71 had an unstageable pressure ulcer to the coccyx (tailbone) which measured 6.5 centimeters (cm) long by 6.5 cm wide and 1.6 cm deep. Resident #162 On 9/22/20 at 11:31 AM, 12:45 PM, 1:49 PM, and 1:54 PM, R162 was observed to be laying in bed on their back with the head of the bed up slightly (less than 30 degrees), with heel lift boots on and lower legs elevated. No positioning devices were observed to the sides to offload pressure from the buttocks and lower back and tailbone area. On 9/22/20 at 4:32 PM, R162 was observed seated in a high back wheelchair, dressed in a gown, and appeared asleep as before with their head back and mouth open. On 9/23/20 at 8:40 AM, 10:50 AM, and 12:20 PM, R162 was observed to be laying in bed on their back with the head of the bed up slightly (less than 30 degrees), with heel lift boot on and lower legs elevated. No positioning devices were observed to the sides to offload pressure from the buttocks and lower back/tailbone area. The tubing for the urinary catheter curled on the floor at the right side of the bed. On 9/23/20 at 10:34 AM, R162 continued on their back in bed, care was provided by the Nurse I and the tubing for the urinary catheter remained on the floor after the nurse left around 10:50 AM. On 9/23/20, from 12:38 PM to 12:55 PM, the Occupational Therapist (OT) evaluated R162. R162 was observed to have weakness and decreased range of motion on the left side verses the right. R162 continued on their back in bed after the OT evaluation was completed. R162 denied tailbone or buttock pain. R162 reported they did not roll onto their side during the day, but did at night. On 9/23/20 at 1:00 PM, Nurse I entered into R162's room with pain medication, patient remained on their back in bed, heels and head of bed observed same as before. On 9/23/20 at 3:50 PM, wound care to the left heel was observed with staff. R162 continued on their back in bed after care was completed. On 9/24/20 at 9:31 AM, R162 was observed to be in bed laying on their back. The head of the bed was up slightly. R162 appeared asleep with their head back and mouth open. A review of the facility records for R162 revealed an admission into the facility on [DATE] and [DIAGNOSES REDACTED]. A review of the MDS assessment dated [DATE] indicated impaired cognition and the need for extensive assist of two persons for bed mobility and total assist of two persons for transfer. The care plan interventions dated 09/02/20 indicated Encourage/assist to reposition and or turn frequently for pressure relief and If resident refuses treatment, confer with resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. Document alternative methods. On 9/23/20 at 3:37 PM, the Director of Nursing (DON) was asked about the positioning of R71 and R162 and reported, they did not think R71 moves much on their own but, has multiple bowel movements daily so R71 does get moved around when changed. The DON continued, R162 can move as they will fight staff at times, but does not. On 9/23/20 at 3:47 PM, Certified Nurse Assistant (CNA) K was observed to enter and exit the room of R71 and reported they had completed catheter care, but no incontinence care. A review of the facility policy titled Physical Function dated June 2008 revealed: 7. Staff uses positioning devices/pillows as appropriate to assist the resident in maintaining pressure reduction and alignment while in bed.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe transfer for one sampled resident (R26), resulting in a fall, broken femur with hospitalization and surgical repair, decrease in functioning, and resident feelings of frustration. Findings include: On 9/22/20 at 9:18 AM, during the initial tour, R26 was queried regarding the care received in the facility. R26 was observed lying in bed and stated, They broke my femur! Staff put me in the shower room. They were supposed to stay with me but left me. I fell and broke my left femur. It was an aide .still works here. I was getting pretty good at getting up and dressed now they don't want me to get up in my chair. They don't trust me getting up by myself. The resident indicated they were currently receiving therapy services and had started the services after breaking their leg. R26 continued, I had to go to the hospital and get it fixed. They put a metal pipe in from knee to hip. (The aide - Resident Care Aide (RCA) O) went out into the hallway to talk to somebody. I said, 'Help me I'm ready to fall.' (The aide) couldn't keep me up. I was standing up. But (the aide) wasn't supposed to leave at all! On 9/22/20 at 11:50 AM, upon further interview with R26, the resident indicated they are blind in their left eye and have partial sight in their right eye. When queried if staff had asked about what had happened in the shower room, R26 stated, I told staff that I was left in the shower room when I fell but they didn't say anything. When queried how long the aide stepped out of the room, R26 stated, I don't know. When queried what they were doing, R26 stated, I was holding onto the bar on the wall standing in

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) the bathroom. I had already taken a shower. (The aide) completely left the room. R26's roommate, R25, was present at the time of the interview and stated, That's what (R26) told me, too. They (aide) left to talk to some staff in the hallway. A review of R25's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating an intact cognition. A review of R26's MDS assessment dated [DATE] revealed the resident had a BIMS score of 15/15, indicating an intact cognition, with medical [DIAGNOSES REDACTED]. Further review revealed the resident requires extensive assistance from two or more staff for transfers. A the time of the fall, R26's MDS assessment dated [DATE] indicated the resident required extensive assistance from one staff for transfers. A review of R26's medical record revealed the following progress note written by Licensed Practical Nurse (LPN) Q: 3/1/2020 15:08 (3:08 PM), SBAR (Situation, Background, Assessment, Recommendation) Summary: .RN Assessment/LPN Appearance of resident - What I think is going on with the resident is: crying in pain .Additional Nursing Notes as applicable: CNA (Certified Nursing Assistant/RCA) reported to nurse that resident fell on the floor writer summoned into the shower room observed (R26) lying on (their) back LLE (left lower extremity) twisted knee area red and swollen crying in pain EMS (emergency medical service) called for transport . On 9/23/20 at 10:45 AM, RCA P was queried regarding R26's fall that occurred on 3/1/20. RCA P stated, I do remember (R26) falling and fracturing their femur but I wasn't working with (the resident) that day. I believe it was (RCA O). On 9/23/20 at 10:52 AM, an attempt to interview RCA O was made via phone call. A voicemail was left for call back. On 9/24/20 at 10:45 AM, LPN Q was interviewed regarding R26's fall on 3/1/20 that resulted in a fractured femur. LPN Q was queried what happened and stated, I was in the hallway, the aide called for me to go to the shower room. The aide put (R26) in there on the toilet. For some reason (R26's) knees buckled up and (they) ended up on the floor. LPN Q was queried who the aide was and indicated they believed it was RCA O. LPN Qcontinued and stated, The aide called me to go in there and I actually observed (R26) on the floor. When I talked to (RCA O) they said they were in the room trying to get the resident off the toilet and (R26's) knees buckled up and they fell . When queried if RCA O had left the shower room, LPN Q stated, I don't think so .I don't know if (RCA O) left (R26) on the toilet and went to a different section of the shower room. When queried regarding R26's appearance when they saw the resident on the floor, LPN Q indicated the resident was wearing clothing and stated, I saw (R26's) knees were swollen and they were calling my name. I knew it was broken. When queried regarding R26's transfer status, LPN Q stated, Right now, (R26) is a hoyer, at that time I'm not certain, I think maybe extensive one person assist. When queried if they observed a gait belt around the resident and queried regarding RCA O using the gait belt and the resident still falling, LPN Q stated, It happened so quick, when I talked to (RCA O) I didn't personally see the gait belt but (RCA O) was saying that they had it. I just don't remember. On 9/24/20 at 11:04 AM, a second attempt to interview RCA O was made via phone call. A voicemail was left for call back. No call back from RCA O was received prior to survey exit. On 9/24/20 at 12:14 PM, R26 was interviewed to confirm the details surrounding the fall they sustained on 3/1/20. R26 was asked if RCA O had been assisting them when they fell and if they had a gait belt on. R26 replied, They broke my femur! (RCA O) went out and talked to some girls in the hall. I told (RCA O) I was falling, they had helped me stand up, then I held onto the bar. My wheelchair was back against the wall. Then (the aide) went out into the hallway. I was standing when they went to the hallway. I said 'I'm falling!' (RCA O) came and tried to help me when I was falling I said, 'Grab my wheelchair!' The aide didn't grab the wheelchair (they) held onto me. And I fell . No gait belt. I ended up on the floor breaking my femur bone. I can't figure out why (RCA O) left me! It's frustrating. I don't know why. On 9/24/20 at 12:45 PM, RCA T and RCA P were seen walking in the hallway. Neither RCA was observed to have a gait belt with them. On 9/24/20 at 12:46 PM, RCA S was observed in the hallway with no gait belt. When queried if they had been provided with one, RCA S stated, Yes it's in my locker in the locker room. I'll go get it. RCA D was observed in the hallway at this time with no gait belt. On 9/24/20 at 12:49 PM, RCA U was observed in the hallway with no gait belt. When queried if they had been provided with one, RCA U stated, It's in my bag. RCA U then went into the clean utility room on the unit and stated, Oh, it's gone. On 9/24/20 at 12:55 PM, the Director of Nursing (DON) was interviewed and indicated they had done the investigation on R26's fall on 3/1/20. When queried what was found, the DON stated, The resident was in the shower room with an RCS (RCA). The resident felt a pain in their leg and lost their footing. They found that the resident had a complete occlusion at the hospital. The resident was alert and oriented the entire time. I know the aide was in the room with (R26) and (the resident) was an extensive one assist so (they) followed the care plan. When queried regarding the resident's statement about the event, the DON stated, fell trying to transfer to the wheelchair. When asked if that was all the resident stated happened, the DON stated, That's all the resident said. When asked how the resident was able to fall hard enough to the ground to break their leg if they were being assisted by the aide and a gait belt, the DON stated, (RCA O) said they were trying to help transfer (R26) when (the resident) moved very fast, and tried to get the wheelchair. When asked if R26 stated that their wheelchair was not near them at the time of the fall, the DON stated, No, (R26) said their leg hurt and they fell trying to get to the wheelchair. That's what (R26) told the hospital as well. When queried regarding gait belts in the facility, the DON stated, (Staff) is encouraged to keep them on their person. All staff have been provided with gait belts and they are available on the units. A review of the facility's investigation into R26's fall on 3/1/20 revealed the following: Provide detailed description of event/allegation: (R26) was being transferred from the toilet to .wheelchair with the assistance of (RCA O), Resident care specialist when (R26) fell on to the floor. Assessment of resident/describe injury: Closed fracture of shaft of left femur. Resident interview summary: (R26) stated that (they) 'fell trying to transfer to wheelchair.' (No further details provided). Immediate resident protection initiated: Resident was transferred to (hospital) for further evaluation. Causal/Contributing factors and observations (May include information from witness interviews, medical record review, environmental observations, equipment, etc.): Left sided [MEDICAL CONDITION] and [MEDICAL CONDITION], Occlusion of the left common and external iliac artery. Three witness statements were included in the investigation. The statements were reviewed and revealed: I was the charge nurse for one east on 3/1/20 from 7 AM until 3 PM I was charting at the nurse's station when I heard (RCA O) calling for help. I got up immediately and went into the shower room. I observed (R26) laying on (their) back on the floor. I could visibly see deformity to (their) left leg. I instructed (RCA O) not to leave (R26) and not to move (them) and I called for help. The nurse caring for (R26) called 911. (R26) was alert and crying. I asked (R26) what had happened, (they) said that (they were) trying to transfer into the wheelchair and that (they) just didn't make it . Signed by LPN V. .I seen the resident care specialist (RCA O) take (R26) into the bathroom to change (them) .At 2:10 PM I heard (RCA O) calling for help. Another nurse (LPN V) and I entered the shower room and witnessed (R26) lying on the floor on (their) back .left leg was twisted and I could see swelling and redness. I immediately called 911 . Signed by LPN Q. .I helped (R26) into the bathroom around 2:10 PM. Once (they were) done using the toilet, I helped (them) get dressed and began to assist (R26) with transferring from the toilet to the wheelchair. (R26) was fully dressed and had on .tennis shoes. I had (their) wheelchair positioned in close proximity and the gait belt on .(R26) is weak on (their) left side. I began to help (R26) transfer when all of a sudden (they) just started moving very fast. I tried my best to get (them) into the wheelchair but (they) only got onto a part of the seat and started falling to the floor. I called out for help, the charge nurses came in . Signed by RCA O. A review of the facility's policy/procedure titled, Fall Management, revised July 2017, revealed, POLICY: The facility assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and/or functional programs, as appropriate, to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluates each resident ' s fall risks. A Care Plan is developed and implemented, based on this evaluation, with ongoing review .When a resident is found on the floor, the facility is obligated to investigate to determine how the resident got there and put into place an intervention to minimize it from recurring. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred . A review of the facility's policy/procedure titled, Physical Function, revised June 2008, revealed, Residents' abilities in activities of daily living do not diminish unless circumstances of their clinical condition demonstrate the decline is unavoidable. These activities include the resident's ability to: Transfer and ambulate, Feed themselves, Dress themselves, Perform personal hygiene; and use the toilet, move freely in bed .Guidelines: .Staff uses gait belts for safety during transfers .
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.**

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	235405	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON AIRE HEALTHCARE CENTER	17001 17 MILE RD CLINTON TOWNSHIP, MI 48038

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to limit as needed (PRN) [MEDICAL CONDITION] medications to 14 days and document the need for the medication affecting two sampled residents (R27 and R53) of six residents reviewed for unnecessary medications with the potential for adverse reactions from prolonged use of the medication. Findings include: R27 On 9/22/20 at 10:27 AM, R27 was interviewed regarding care received at the facility. R27 was calm and easily distracted during the interview and did not answer any questions appropriately. R27 self-propelled into the hallway and was redirected by staff to wear a mask. R27 remained calm but declined to wear a mask. Record review of R27's Electronic Health Record (EHR) revealed R27 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed that R27 had a Brief Interview for Mental Status (BIMS) score of two out of 15 indicating a severely impaired cognition and needed extensive assistance with Activities of Daily Living (ADLs). Review of R27's Medication Administration Record [REDACTED]. Scheduling details of the order revealed that the medication had an indefinite end date. Further review of the MAR indicated [REDACTED]. Review of R27's progress notes regarding behaviors justifying the administration of those doses was not found. R53 On 9/22/20 at 10:20 AM, R53 was observed sleeping in bed and did not respond to knocking or verbal greeting. On 9/22/20 at 12:58 PM, R53 was observed being prompted to eat more lunch and said No, and fell asleep. On 9/23/20 at 8:04 AM, R53 was observed sleeping in bed and did not respond to knocking or verbal greeting. On 9/23/20 at 10:26 AM, R53 was observed receiving care by Hospice Nurse R. During the care R53 opened eyes but did not speak. R53 was observed sleeping on 9/23/20 at 12:34 PM and 2:55 PM. Record review of R53's EHR revealed that R53 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS revealed R53 had a BIMS score of three out of 15 indicating a severely impaired cognition and needed extensive assistance with ADLs. Review of R53's MAR indicated [REDACTED]. - Order Date - 08/18/2020. The scheduling detail for this order indicated an indefinite end date. Further review of the MAR indicated [REDACTED]. Review of R53's progress notes revealed rationale for those administrations was not documented. On 9/24/20 at 4:02 PM, The Director of Nursing (DON) was asked about the facility's policy and procedure regarding the use of PRN [MEDICAL CONDITION] medications and stated, Both of those residents are [MEDICAL CONDITION] and hospice. The psychologist would say the need to discontinue the meds would be unjustified. Review of the facility's policy and procedure titled, [MEDICAL CONDITION] Management dated, Revision Date: November 2017 revealed on page 3, PRN orders for [MEDICAL CONDITION] medications are limited to 14 days, except as provided by Federal regulation, and cannot be renewed unless the Attending Physician or prescribing Licensed Practitioner evaluates the resident for the appropriateness of that medication. If the Attending Physician or prescribing Licensed Practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days and CANNOT be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label medication containers per professional standards affecting five residents (R40, R41, R63, R66, and R74) and discard expired biologicals affecting all residents in the 100 hall that had a urine dip-stick test ordered with the potential of residents receiving other resident's medications and or receiving outdated and ineffective medications and inaccurate test results. Findings include: On [DATE] at 10:38 AM, a medication labeling and storage observation was conducted with Nurse A. A vial of [MEDICATION NAME] (insulin) for R63 was not labeled with the date opened on the vial. A vial of [MEDICATION NAME] for R66 was not labeled with the resident's name or the date opened on the vial. An open vial of Artificial Tears was only labeled with a room number. A vial of Artificial Tears for R40 was not labeled with the resident's name on the vial. The [MEDICATION NAME] (for [MEDICAL CONDITION] or [MEDICAL CONDITION]) for R74 was not labeled with the resident's name on the inhaler. The Breo (for [MEDICAL CONDITION]) for R41 was not labeled with the resident's name or the date opened on the inhaler. Nurse A was asked about the facility's policy and procedure regarding the labeling of medication containers and stated, They should be labeled. On [DATE] at 10:49 AM, a medication labeling and storage observation was conducted in the 100 hall medication room with Nurse A. Two containers of urinalysis test strips had expired on [DATE]. Nurse A was asked about the facility's policy and procedure regarding the expiration dates of medications and biologicals and stated, They should be tossed. On [DATE] at 4:02 PM, the Director of Nursing (DON) was asked about the facility's policy and procedure regarding the labeling and storage of medication and stated, They should be labeled properly and any that are expired should have been discarded. On [DATE] at 4:53 PM, the facility's policy and procedure was requested and the facility submitted the DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES Medication Storage and Labeling guidelines dated, (,[DATE]). Review of the document revealed, Were medications and biologicals labeled in accordance with currently accepted professional principles. and Multi-dose vials which have been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview, and record review, the facility failed to ensure meals were served in palatable manner, for five residents that attended the group meeting (#'s 17, 20, 23, 37, and 64) questioned for food palatability, resulting in dissatisfaction with the meal experience. Findings include: On 9/22/20 at 2:39 PM, during the resident council group meeting all five residents were asked about the food temperature. All five residents agreed that the food is sometimes cool or cold, but it depends on the unit. One resident explained, Unit 1 East is served last and the food is sometimes cold. On 9/23/20 at 12:08 PM, a meal cart was delivered to Unit 1 East. A request was made for the last tray. A tray was removed from the meal cart and food temperatures tested by the Dietary Manager at 12:30 PM. The following temperatures were obtained using a metal stem thermometer: Tuna salad sandwich 61.5 F (Fahrenheit) Garden pasta salad 65.3 F Orange sherbet 16.9 F Coffee 134.0 F The Dietary Manager was interviewed after testing and was asked the expectations for serving temperatures. The Dietary Manager stated 41F - and under for cold food and 135F or above for hot food, and the coffee under 150F for safety reasons. The Manager continued and stated, We base temperature of food on resident preferences. The Manager was asked if the facility served each resident food at the preferred choice and the Dietary manager stated, Yes. A review of the facility's policy titled, Food: Preparation, dated, 9/17 noted, All foods are prepared in accordance with the FDA Food Code. Procedures: . 13. All foods will be held at appropriate temperatures, greater than 135 F for hot holding, and less than 41 F for cold food holding .
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 ensure proper cooling procedures and and proper thawing procedures were followed for potentially hazardous food items, and failed to ensure staff conducting dish washing operations washed their hands after handling soiled dishware and before handling clean dishware, resulting in the increased potential for foodborne illnesses and cross contamination. These deficient practices had the potential to affect all residents that received food from the kitchen. Findings include: On 9/22/18, during a tour of the kitchen between 8:30 AM and 9:15 AM with Certified Dietary Manager (CDM) W, the following items were observed: In the reach-in cooler, there was a 12 quart container of chicken soup, tightly covered with plastic wrap, dated 9/21 with a use by date of 9/23. When queried, CDM W confirmed that the soup had been made on 9/21. The internal temperature of the soup was measured to be 55 degrees

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) Fahrenheit. Review of a cooling log noted the following: 9/21 Soup 3:00 PM 139 (degrees Fahrenheit), 5:00 PM 69 (degrees Fahrenheit), 7:00 PM 39 (degrees Fahrenheit). When queried as to how the soup went from 39 degrees Fahrenheit at 7:00 PM on 9/21, to 55 degrees Fahrenheit on 9/22 at 8:30 am, CDM W stated Well, they've been in and out of the cooler this morning. According to the 2013 FDA Food Code section 3-501.15 Cooling Methods, 1. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: 1. Placing the FOOD in shallow pans; 2. Separating the FOOD into smaller or thinner portions; 3. Using rapid cooling EQUIPMENT; 4. Stirring the FOOD in a container placed in an ice water bath; 5. Using containers that facilitate heat transfer; 6. Adding ice as an ingredient; or 7. Other effective methods. 2. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: 1. Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and 2. Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. In the 3 compartment sink, there was a bowl of chicken breasts thawing under running water. The temperature of the running water was measured to be 110 degrees Fahrenheit, and the internal temperature of the chicken was measured to be 67 degrees Fahrenheit. Dietary Staff Y was queried about the thawed chicken breasts and stated, I put it in the sink around 5:30-6:00 this morning. When queried as to what temperature the running water used for the thawing chicken should be, Dietary Staff Y stated that she wasn't sure. According to the 2013 FDA Food Code section 3-501.13 Thawing, Except as specified in (D) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be thawed: 1. (A) Under refrigeration that maintains the FOOD temperature at 5C (41F) or less; or 2. (B) Completely submerged under running water: (1) At a water temperature of 21C (70F) or below. Dietary Staff X was observed wearing disposable gloves, rinsing soiled dishware to be sent through the dish machine. Dietary Staff X was then observed going to the clean side of the dish machine, and began putting away the clean items, without first changing gloves or washing her hands. When CDM W was queried about Dietary Staff X going from soiled to clean dishware without any handwashing in between, CDM W stated, Oh, bad girl. According to the 2013 FDA Food Code section 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: .(E) After handling soiled equipment or utensils;.
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** Based on observation, interview, and record review, the facility failed to maintain accurate medical records for one sampled resident (#89) of 22 reviewed for medical record documentation, resulting in the potential for staff and providers lacking accurate information to care for residents. Findings include: On [DATE] at 12:19 PM, Resident #89 was observed sitting up in bed watching television. Resident #89 was asked about the care at the facility, and stated, I sometimes want more food at breakfast, but that's it. A review of R89's medical record noted under their picture Resident Code Status: Do Not Resuscitate - DNR. Further review of R89's medical record did not note a DNR physician's orders [REDACTED]. R89's record revealed a form titled, DO-NOT-RESUSCITATE ORDER signed: (POA), date: [DATE]. A review of R89's Minimum Data Set (MDS) assessment dated [DATE] and medical record revealed that resident was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively impaired and required extensive assistance from staff for activities of daily living. A review of R89's care plan noted, Focus: I choose to die with dignity and my wish is to be kept free from any artificial interventions that would prolong my life including CPR (cardiopulmonary resuscitation), tube feeding, and IVs (Intravenous) because I have DNR Date Initiated: [DATE], Revision on: [DATE]. Goal: I will have all of my wishes and advanced directives honored until I request otherwise, or until the next review period Date Initiated: [DATE] Revision on: [DATE]. Interventions/Tasks: Me and my family have been educated on Advanced Directives and I have chosen to be DNR Code Status. Please provide no CPR. Date Initiated: [DATE] Revision on: [DATE]. A review of R89's assessments noted, Social Service assessment Note. Quarterly, dated [DATE], Resident Status: Full Code. Summary Note: resident whom is alert and oriented to ,[DATE] completed assessment to the best of (R89's) cognitive ability, resident offered no mood distress nor exhibit any, no sig (significant) changes noted this quarter code status to remain full code with LTC (long term care) per son (POA) resident is followed by psych and ancillary services as needed, continue with POC (plan of care). The assessment prior to this assessment revealed Social Service assessment Note. Annual dated, [DATE]: Resident status: DNR, Resident .completed BIMS/PHQ-9 (Brief Interview for Mental Status/Patient Health Questionnaire) to the best of (R89's) cognitive ability, resident offers no mood distress nor exhibits any, no sig changes noted writer spoke to resident DPOA this evening discussed code status of DNR to remain in effect with LTC at facility no concerns offered with resident care continue with POC (plan of care). On [DATE] at 9:15 AM, the Social Services Director H was asked about the assessment dated [DATE] with an indication of full code. The Social Service Director H stated, (R89) is a DNR. There was a discussion with (R89's) POA, because the POA wanted (R89) to be a full code, but (R89) wanted to be a DNR. The Social Service Director H continued and explained, that the documentation on [DATE] was done in error. R89 has been a DNR since [DATE] and was not changed to a full code. The Social Service Director H was also asked if the facility required a physician's orders [REDACTED]. On [DATE] at 2:35 PM, the Director of Nursing (DON) was asked facility's expectation for documentation. The DON stated, That it is precise, accurate, and timely. A review of the policy titled Documentation dated, February 2017, noted, Healthcare personnel will complete documentation as outlined below and will record in the medical record using accepted principles of documentation . Be Accurate. Verify right resident, right event, right date/time, right location, etc. (See Charting Errors and/or Omissions, in the Procedure Section below) . Charting Errors and/or Omissions 1. If an error is made while recording the information in the medical record, line through the error with a single line and correct the error. Sign or initial next to the mistaken entry followed by the date. When space does not exist for making a legible correction, cross reference the note to an addendum .
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 maintain urinary catheter drainage bag/tubing, oxygen tubing, and oxygen humidifier bottle in a sanitary manner affecting three sampled residents (R49 and R53 and R162), with the potential for the preventable spread of infection. Findings include: R49 On 9/23/20 at 11:30 AM, R49 was observed lying in bed with the bed in its lowest position. It was observed that R49 had a urinary catheter and the drainage bag was in a dignity bag and part of the bag and some of the tubing was partially resting on the floor. On 9/23/20 at 2:55 PM, R49 was again observed lying in bed and the catheter drainage bag was completely on the floor along with some of the tubing. On 9/23/20 at 3:47 PM, R49 was observed lying in bed and the catheter drainage bag was part of the way out of the dignity bag and was lying on the floor with part of the tubing. Certified Nursing Assistant (CNA C) was asked about the facility's policy and procedure regarding maintaining catheter drainage bags in a sanitary manner and stated, It should not be on the floor but (the resident's) bed has to be in the lowest position. CNA C then repositioned the dignity bag but the dignity bag and part of the tubing remained touching the floor. On 9/24/20 at 9:16 AM, R49 was observed in bed eating breakfast. The bed was in the lowest position. The catheter drainage bag was observed to be partly on the floor with part of the tubing. CNA D was asked about the facility's policy and procedure regarding maintaining catheter drainage bags in a sanitary manner and stated, They should not be touching the floor. CNA D then adjusted the straps on the dignity bag to suspend the catheter drainage bag and the tubing higher on the bed frame. Review of R49's Electronic Health Record (EHR) revealed R49 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated , 07/10/20 revealed R49 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating an intact cognition and needed extensive assistance with Activities of Daily Living (ADLs) including toileting and hygiene. R53 On 9/22/20 at 11:10 AM, R53 was observed in bed sleeping. It was observed that R53 had oxygen therapy in progress. The nasal cannula (delivers oxygen to the nose) was in R53's nose properly. The tubing was observed lying on the floor and connected to a humidifier bottle which was sitting on the floor in front of the oxygen concentrator. On 9/22/20 at 11:28 AM, Nurse B was asked about the facility policy and procedure for maintaining oxygen equipment in a sanitary manner and stated, It should be in the holder. Nurse B then placed the oxygen humidifier in the holder on the oxygen concentrator and off the floor. Record review of R53's EHR revealed that R53 was admitted into the

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CLINTON AIRE HEALTHCARE CENTER	**17001 17 MILE RD CLINTON TOWNSHIP, MI 48038**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS revealed R53 had a BIMS score of three out of 15 indicating a severely impaired cognition and needed extensive assistance with ADLs. R162 On 9/23/20 at 8:40 AM, 10:50 AM, and 12:20 PM, R162 was observed to be laying in bed on their back with the head of the bed up slightly. The tubing for the urinary catheter was curled on the floor at the right side of bed. A review of the facility records for R162 revealed an admission into the facility on [DATE] and [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment dated [DATE] indicated impaired cognition and the need for extensive assist of two persons for bed mobility and total assist of two persons for transfer. The resident's care plan goal related to catheters dated 08/20/20 revealed: I will show no (sign symptoms) s/sx of urinary infection through review date. On 9/24/20 at 10:00 AM, the Infection Control Preventionist/Assistant Director of Nursing (Nurse L) was asked about the facility's policy and procedure regarding maintaining urinary catheters and oxygen equipment in a sanitary manner and stated, It looks like there will be some in-servicing. They should not be on the floor. Review of the facility's policy and procedure titled Urologicals Clinical Troubleshooting Guide Book dated 2007 revealed on page 4, Never put the urinary drainage bag on the floor to prevent bacteria and dirt on the floor from attaching to drainage bag. Anyone handling the bag can then spread bacteria to catheter or other patients or surfaces. Review of the facility's policy's and procedures titled Oxygen Administration and Oxygen Storage & Assembly revealed the placement of the oxygen humidifier and tubing was not addressed.