STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 461 Based on interview and record review, the facility failed to notify the physician and responsible party of changes for one (Resident #2) of 3 reviewed for notification of changes, resulting in Resident #2's physician not being notified of low pulse and medication that was held and Resident #2's responsible party not being notified of a new medication that was ordered. Findings include: Review of the medical record revealed Resident #2 (R2) admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R2 scored 4 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Review of R2's Physician order [REDACTED]. When giving Dig monitor pulse if< than 60, hold Dig and notify the physician. Review of the Medication Administration Records (MARs) and the Progress Notes revealed [MEDICATION NAME] was held by Licensed Practical Nurse (LPN) G on the following dates due to a pulse of less than 60 and the physician was not notified, per orders: 9/16/19, 9/17/19, 9/21/19, 9/22/19, 10/1/19, 10/21/19, 11/3/19. LPN E administered [MEDICATION NAME] to R2 when the pulse was documented as less than 60 on the following dates: 11/19/19, 11/23/19, 11/28/19. There was no pulse documented with administration of [MEDICATION NAME] on the following dates: 8/31/19, 8/31/19, 9/1/19, 9/2/19, 9/3/19, 9/4/19, 9/5/19, 9/6/19, 9/7/19, 9/8/19, 9/9/19, 9/10/91, 9/11/19. 9/12/19, 9/13/19, 9/14/19, and 9/24/19. In an interview on 3/4/20 at 9:22 AM, LPN E reported she gave the [MEDICATION NAME] on 11/19/19, 11/23/19, and 11/28/19 when R2's pulse was below 60 because R2's daughter/responsible party wanted her to. When asked about the pulse not being documented in August and September, LPN E reported it must not have popped up on the MAR indicated [REDACTED]. In an interview on 3/4/20 at 10:20 AM, LPN G reported she held R2's [MEDICATION NAME] when her pulse was less than 60. When asked about notifying the physician, LPN G reported that would only be done if the [MEDICATION NAME] was held for three to four days in a row. LPN G reported she never notified the physician when the [MEDICATION NAME] was held and was not aware there was an order to do so. When asked about the pulse being documented with the administration of the [MEDICATION NAME], LPN G reported the pulse should be on the MAR. In an interview on 3/4/20 at 9:45 AM, Registered Nurse (RN) Supervisor D reported the physician should be notified if a pulse was less than 60 and [MEDICATION NAME] was held. RN Supervisor D reported the notification should be documented in the progress notes. RN Supervisor D reported she did recall that R2's daughter/responsible party wanted the [MEDICATION NAME] administered even if the pulse was less than 60, but reported there should have been documentation that the physician was notified of that. Review of the Communication with Physician Note dated 1/1/20, revealed Patient is not getting very much pain relief from the [MEDICATION NAME] every 6 hours. She is crying out in pain around every 4 hours. Do you want to order anything else? It is evident that she is painful not bc (because) of the cursing and swearing but because just touching her arm or legs she had pain. Review of the physician's orders [REDACTED]. There was no documentation in the medical record that R2's activated Power of Attorney was notified of the new order for [MEDICATION NAME]. In a telephone interview on 3/3/20 at 1:42 PM, R2's Responsible Party/Activated Power of Attorney F reported she was not aware of the order for [MEDICATION NAME] until after she obtained copies of R2's medical records, which was after R2 left the facility. In an interview on 3/4/20 at 11:00 AM, Director of Nursing (DON) B reported she was not surprised nurses administered the Digxoin if R2's pulse was under 60 because R2's daughter ran the show. When asked what staff should have done, DON B reported the nurses should have held the [MEDICATION NAME] and notified the physician. DON B reported she thought holding [MEDICATION NAME] and notifying the physician of a pulse under 60 was a standing order. When asked about the notification of R2's responsible party regarding the new order for [MEDICATION NAME], DON B reported it would be a courtesy, not a requirement.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 461 Based on interview and record review, the facility failed to ensure the pharmacist reported irregularities to the attending physician, medical director, and Director of Nursing (DON) for one (Resident #2) of one reviewed for medication regimen review, resulting in the pharmacist not recognizing a [MEDICATION NAME] level was not obtained and Resident #2 being hospitalized with a [DIAGNOSES REDACTED].#2 (R2) admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R2 scored 4 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Review of R2's Physician order [REDACTED]. When giving Dig monitor pulse if< than 60, hold Dig and notify the physician. Another physician's orders [REDACTED]. Review of R2's labwork dated 8/3019 revealed a [MEDICATION NAME] level was never performed. The TSH level was 5.09. A normal level was 0.36-3.74. Review of R2's Physician order [REDACTED]. The physician's orders [REDACTED]. The medical record revealed the recheck in 2 months was never performed. R2's TSH was rechecked on 12/11/19, after she returned from the hospital, and was 8.79. Review of the Medication Administration Records (MARs) and the Progress Notes revealed [MEDICATION NAME] was held by Licensed Practical Nurse (LPN) G on the following dates due to a pulse of less than 60 and the physician was not notified, per orders: 9/16/19, 9/17/19, 9/21/19, 9/22/19, 10/1/19, 10/21/19, 11/3/19. LPN E administered [MEDICATION NAME] to R2 when the pulse was documented as less than 60 on the following dates: 11/19/19, 11/23/19, 11/28/19. There was no pulse documented with administration of [MEDICATION NAME] on the following dates: 8/31/19, 8/31/19, 9/1/19, 9/2/19, 9/3/19, 9/4/19, 9/5/19, 9/6/19, 9/7/19, 9/8/19, 9/9/19, 9/10/91, 9/11/19. 9/12/19, 9/13/19, 9/14/19, and 9/24/19. In an interview on 3/4/20 at 9:22 AM, LPN E reported she gave the [MEDICATION NAME] on 11/19/19, 11/23/19, and 11/28/19 when R2's pulse was below 60 because R2's daughter/responsible party wanted her to. When asked about the pulse not being documented in August and September, LPN E reported it must not have popped up on the MAR indicated [REDACTED]. In an interview on 3/4/20 at 10:20 AM, LPN G reported she held R2's [MEDICATION NAME] when her pulse was less than 60. When asked about notifying the physician, LPN G reported that would only be done if the [MEDICATION NAME] was held for three to four days in a row. LPN G reported she never notified the physician when the [MEDICATION NAME] was held and was not aware there was an order to do so. When asked about the pulse being documented with the administration of the [MEDICATION NAME], LPN G reported the pulse should be on the MAR. In an interview on 3/4/20 at 9:45 AM, Registered Nurse (RN) Supervisor D reported the physician should be notified if a pulse was less than 60 and [MEDICATION NAME] was held. RN Supervisor D reported the notification should be documented in the progress notes. RN Supervisor D reported she did recall that R2's daughter/responsible party wanted the [MEDICATION NAME] administered even if the pulse was less than 60, but reported there should have been documentation that the physician was notified of that. When asked about R2's [MEDICATION NAME] level not being done on admission and the TSH level not being rechecked in October 2019, RN Supervisor D reported that at that time, the clerk was new to the facility. RN Supervisor D reported she was not sure how the labwork was missed. When asked if anyone verified that the clerk entered the orders correctly or that the order was completed as ordered, RN Supervisor D stated No, not really. I just ask if admit labs have been done. I don't go back in and research what has been done. In an interview on 3/4/20 at 11:00 AM, Director of Nursing (DON) B reported R2 did not have an admission [MEDICATION NAME] level done as ordered. DON B reported the missing labwork was discovered when R2 was transferred to the hospital and diagnosed with [REDACTED]. When asked if there was any double check system done after the ward clerk entered laboratory orders, DON B reported the facility had a nurse to nurse double check system in place for medications. When asked if it was done for labwork, DON B stated not necessarily, probably not. DON B reported she was not aware that R2's TSH level was not repeated in October, as ordered and was not aware there was no pulse documented with the administration of multiple [MEDICATION NAME] doses. DON B reported she was not surprised nurses administered the Digxoin if R2's pulse was under 60 because R2's daughter ran the show. When asked what staff should have done, DON B reported the nurses should have held the [MEDICATION NAME] and notified the physician. DON B reported she thought holding [MEDICATION NAME] and notifying the physician of a pulse under 60 was a standing order. Review of the Nursing Note dated 12/3/19, revealed resident sitting at desk in wheelchair. resident slouched over and became unresponsive. resident has right side facial droop. right pupil unresponsive. unable to move arm on right side did not know own name. R2 was transferred to the hospital. Review of the hospital History and Physical dated 12/4/19, for the admission date of [DATE], revealed When the patient presented to the ER she was found to have elevated [MEDICATION NAME] level and complained of chest pain, and had unusual changes on her EKG. R2's [MEDICATION NAME] level was 2.89 ng/mL, which was a critically high level. A normal [MEDICATION NAME] level should be between 0.5-2 ng/mL. R2's [DIAGNOSES REDACTED]. R2 readmitted to the facility on [DATE]. She transferred to the hospital again on 1/10/20 and was not in the facility at the time of the survey. Review of R2's Pharmacy Progress Notes, revealed the pharmacist reviewed R2's medications on 9/5/19, 10/8/19, and 11/11/19. There were no irregularities reported related to the [MEDICATION NAME] level not being performed. In a telephone interview on 3/4/20 at 12:13 PM, Pharmacist I reported if a resident was prescribed [MEDICATION NAME], she would check the medical record for yearly electrolytes and [MEDICATION NAME] level on file from time to time. When asked if she noticed R2 did not have a [MEDICATION NAME] level on file when she conducted the medication regimen reviews on 10/8/19 and 11/11/19 (another pharmacist performed the review on 9/5/19), Pharmacist I stated we had a note to ourselves to ask in a couple months. When asked if she would have noticed that R2 had an order for [REDACTED]. Pharmacist I was unable to determine the date the note was made, but reported R2's medications were reviewed in September, October, November, and December.

F 0757 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 461 Based on interview and record review, the facility failed to ensure adequate monitoring for [MEDICATION NAME] and [MEDICATION NAME] use in one (Resident #2) of two reviewed for medications, resulting in an elevated [MEDICAL CONDITION] Stimulating Hormone (TSH) level and hospitalization with a [DIAGNOSES REDACTED].#2 (R2) admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R2 scored 4 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Review of R2's Physician order [REDACTED]. When giving Dig monitor pulse if< than 60, hold Dig and notify the physician. Another physician's orders [REDACTED]. Review of R2's labwork dated 8/3019 revealed a [MEDICATION NAME] level was never performed. The TSH level was 5.09. A normal level was 0.36-3.74. Review of R2's Physician order [REDACTED]. The physician's orders [REDACTED]. The medical record revealed the recheck in 2 months was never performed. R2's TSH was rechecked on 12/11/19, after she returned from the hospital, and was 8.79. Review of the Medication Administration Records (MARs) and the Progress Notes revealed [MEDICATION NAME] was held by Licensed Practical Nurse (LPN) G on the following dates due to a pulse of less than 60 and the physician was not notified, per orders: 9/16/19, 9/17/19, 9/21/19, 9/22/19, 10/1/19, 10/21/19, 11/3/19. LPN E administered [MEDICATION NAME] to R2 when the pulse was documented as less than 60 on the following dates: 11/19/19, 11/23/19, 11/28/19. There was no pulse documented with administration of [MEDICATION NAME] on the following dates: 8/31/19, 8/31/19, 9/1/19, 9/2/19, 9/3/19, 9/4/19, 9/5/19, 9/6/19, 9/7/19, 9/8/19, 9/9/19, 9/10/91, 9/11/19. 9/12/19, 9/13/19, 9/14/19, and 9/24/19. In an interview on 3/4/20 at 9:22 AM, LPN E reported she gave the [MEDICATION NAME] on 11/19/19, 11/23/19, and 11/28/19 when R2's pulse was below 60 because R2's daughter/responsible party wanted her to. When asked about the pulse not being documented in August and September, LPN E reported it must not have popped up on the MAR indicated [REDACTED]. In an interview on 3/4/20 at 10:20 AM, LPN G reported she held R2's [MEDICATION NAME] when her pulse was less than 60. When asked about notifying the physician, LPN G reported that would only be done if the [MEDICATION NAME] was held for three to four days in a row. LPN G reported she never notified the physician when the [MEDICATION NAME] was held and was not aware there was an order to do so. When asked about the pulse being documented with the administration of the [MEDICATION NAME], LPN G reported the pulse should be on the MAR. In an interview on 3/4/20 at 9:45 AM, Registered Nurse (RN) Supervisor D reported the physician should be notified if a pulse was less than 60 and [MEDICATION NAME] was held. RN Supervisor D reported the notification should be documented in the progress notes. RN Supervisor D reported she did recall that R2's daughter/responsible party wanted the [MEDICATION NAME] administered even if the pulse was less than 60, but reported there should have been documentation that the physician was notified of that. When asked about R2's [MEDICATION NAME] level not being done on admission and the TSH level not being rechecked in October 2019, RN Supervisor D reported that at that time, the clerk was new to the facility. RN Supervisor D reported she was not sure how the labwork was missed. When asked if anyone verified that the clerk entered the orders correctly or that the order was completed as ordered, RN Supervisor D stated No, not really. I just ask if admit labs have been done. I don't go back in and research what has been done. In an interview on 3/4/20 at 11:00 AM, Director of Nursing (DON) B reported R2 did not have an admission [MEDICATION NAME] level done as ordered. DON B reported the missing labwork was discovered when R2 was transferred to the hospital and diagnosed with [REDACTED]. When asked if there was any double check system done after the ward clerk entered laboratory orders, DON B reported the facility had a nurse to nurse double check system in place for medications. When asked if it was done for labwork, DON B stated not necessarily, probably not. DON B reported she was not aware that R2's TSH level was not repeated in October, as ordered and was not aware there was no pulse documented with the administration of multiple [MEDICATION NAME] doses. DON B reported she was not surprised nurses administered the Digxoin if R2's pulse was under 60 because R2's daughter ran the show. When asked what staff should have done, DON B reported the nurses should have held the [MEDICATION NAME] and notified the physician. DON B reported she thought holding [MEDICATION NAME] and notifying the physician of a pulse under 60 was a standing order. Review of the Nursing Note dated 12/3/19, revealed resident sitting at desk in wheelchair. resident slouched over and became unresponsive. resident has right side facial droop. right pupil unresponsive. unable to move arm on right side did not know own name. R2 was transferred to the hospital. Review of the hospital History and Physical dated 12/4/19, for the admission date of [DATE], revealed When the patient presented to the ER she was found to have elevated [MEDICATION NAME] level and complained of chest pain, and had unusual changes on her EKG. R2's [MEDICATION NAME] level was 2.89 ng/mL, which was a critically high level. A normal [MEDICATION NAME] level should be between 0.5-2 ng/mL. R2's [DIAGNOSES REDACTED]. R2 readmitted to the facility on [DATE]. She transferred to the hospital again on 1/10/20 and was not in the facility at the time of the survey. [MEDICATION NAME] is a medicine that is used to treat certain heart conditions. [MEDICATION NAME] toxicity can be a side effect of [MEDICATION NAME] therapy. It may occur when you take too much of the drug at one time. It can also occur when levels of the drug build up for other reasons such as other medical problems you have. The most common prescription form of this medicine is called [MEDICATION NAME] .If you take [MEDICATION NAME] medicine, you should have your blood level checked regularly. Blood tests should also be done to check for conditions that make this toxicity more common. (https://medlineplus.gov/ency/article/ 5.htm)

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.