STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235573	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACEWAY AT COUNTRYSIDE	120 BASELINE RD SOUTH HAVEN, MI 49090

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 0568 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.** This citation pertains to intakes # MI 234, MI 256, and MI 701 Based on interview and record review the facility failed to establish and maintain a system that assures a full, complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf resulting in the potential for all residents participating in the Resident Trust Fund to not receive their personal funds and not meet their highest practicable level of wellbeing. Findings include: Review of the facility form Resident Trust Fund Worksheet revealed that in January of 2019 the Total Balance was $9,713.12, the Trust Fund Ledger Balance was $6,794.74, and the Difference was $2,918.38. Review of the facility form Resident Trust Fund Worksheet revealed that in February of 2019 the Total Balance was $10,283.33, the Trust Fund Ledger Balance was $6,565.64, and the Difference was $3,717.69. Review of the facility form Resident Trust Fund Worksheet revealed that in March of 2019 the Total Balance was $10,265.87, the Trust Fund Ledger Balance was $7,728.37, and the Difference was $2,537.50. Review of the facility form Resident Trust Fund Worksheet revealed that in April of 2019 the Total Balance was $9,564.30, the Trust Fund Ledger Balance was $8,062.41, and the Difference was $1,501.89. Review of the facility form Resident Trust Fund Worksheet revealed that in May of 2019 the Total Balance was $11,586.78, the Trust Fund Ledger Balance was $10,031.71, and the Difference was $1,555.07. Review of the facility form Resident Trust Fund Worksheet revealed that in of June 2019 the Total Balance was $10,168.44, the Trust Fund Ledger Balance was $8,448.99, and the Difference was $1,719.45. During an interview on 03/06/2020 at 3:56 P.M., Business Office manager (BOM) YY reported the Resident Trust Fund account was off. BOM YY stated the first month she was hired I noticed it was off by about $2,000. BOM YY reported that she informed the administrator at the time and the owner of the discrepancy. BOM YY reported that the she would try to find the discrepancy but each month the beginning totals and end totals (were) always $2,000 off. During an interview on 03/13/2020 at 12:31 P.M., Human Resources (HR) G reported no staff member had completed the trust and billing since January 31st (2020) when (Business Office Manager) BOM YY quit. HR G reported prior to BOM YY, BOM P was responsible for the resident personal trust until BOM P abruptly quit in July of 2019. HR G reported, BOM P had been responsible for the resident personal trust since the facility took over from the previous owner in January 2019. BOM O was recently hired and her first day was on 3/9/20. The facility was without a BOM from January 31st until March 9th. HR G reported that when BOM YY quit, HR G was given the responsibility of maintaining records (receipts, petty cash, etc) until a new Business Office Manager was hired. HR G reported that she does not have access to bank statements and cannot perform the full duties of BOM because of this (indicated no staff member had accounted for resident trust money for approximately 5 weeks) During an interview on 3/13/20 at 3:20 P.M., BOM P reported that she had never identified any discrepancies in the Resident Trust Fund account. BOM P reported that she had been responsible for the Resident Trust Fund for greater than 1 year. BOM P reported that she was notified on short notice that she would no longer be responsible for Business Office Manager duties and would be placed in a different department. BOM P reported that she was not satisfied with her new position and quit. BOM P reported that she trained BOM YY for less than a week for the Business Office Manager duties. Review of BOM P's employee file revealed Job Coaching Form dated 3/29/19, Minor policy violation that occurred: delay in follow through w/ (with) re-Billing (sic)-unable to perform job duties .addendum to Warning/Counseling .Failure to address and accurately communicate critical issues regarding departmental performance to prevent A/R delays-jeopardizing the company's financial wellbeing .Recommendation For Improvement .Provide timely & accurate communication & information to 3rd party billing company. Take ownership of responsibilities + ensure a positive attitude with others .Probation period extend x30d (days) Performance Improvement Plan to begin 4/8/19. During an interview on 03/13/2020 at 10:51 A.M., Contracted Accountant (CA) N reported that she attempted to find the discrepancy in the Resident Trust Fund account. CA N reported she was able to look back to January 2019 when the new owners took over the building. CA N reported that she was not able to balance any of the months (indicated a discrepancy in trust fund balance). The information there is so vague. CA N reported that (BOM P) would document outstanding checks to account for the final balance being off but would not document the check numbers or any other identifier to determine which check was outstanding. CA N reported that there were not receipts for all transactions and some transactions were missing altogether. CA N reported she could not identify how many checks were involved in the outstanding check documentation. CA N reported that she could not identify how far back the discrepancies went. CA N reported that she was unable to formulate a final report because of the lack of documentation. CA N reported that the dollar amounts of the Difference changed every month and the difference was always listed as outstanding checks with no check identifier numbers. CA N reported that BOM YY took over after BOM P quit and was not properly trained and was shown how to do the account incorrectly. CA N reported that she believed the account was out of balance prior to the new ownership in January 2019. CA N reported that although there is more money in the account than what there should be, it is still bad. You have someone's money and you don't know where it goes. CA N reported that the Resident Trust Fund account was still in the prior owner's name.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 # MI 285 Based on observation, interview, and record review the facility failed to notify the physician of an abnormal skin assessment and upper respiratory infections and/or symptoms for 8 out of 25 residents (Resident #110, #112, #123, #124, #111, #113, #114, and #116) reviewed for notification of changes, resulting in the lack of assessment, monitoring, documentation and the potential for worsening of condition and delay in treatment. Findings include: Review of the facility policy, Change in Condition dated 8/2018 revealed, Purpose: To provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications. Note: CMS requires: A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is .A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status is either life-threatening conditions, or clinical complications); A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .According to the American Medical Directors Association (AMDA) Clinical Practice Guidelines-Acute Changes in Condition in the Long-Term Care Setting, Immediate notification is recommended for any symptom, sign, or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) prescribed. Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, An incident or occurrence is any event that is not consistent with the routine operation of a health care unit or routine care of a patient Always contact the patient's health care provider whenever an incident happens. Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 358 Resident #110 Review of a Face Sheet revealed Resident #110 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 1/20/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #110 was cognitively intact. Review of the Functional Status revealed that Resident #110 required extensive 1 person assist for bed mobility, dressing, toileting, and personal hygiene and extensive 2 person assistance for transferring. Review of Section M Skin Conditions revealed Resident #110 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an interview on 03/04/2020 at 3:36 P.M., Licensed Practical Nurse (LPN) LL reported that Resident #110 had a pressure ulcer on his back and his buttocks. During an observation on 03/13/2020 at 12:16 P.M., Resident #110's bandage was removed by LPN JJ. Resident #110's bilateral buttocks was a deep purple/red and it was non blanchable. Resident #112 Review of a Face Sheet revealed Resident #112 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #112, with a reference date of 2/20/20 revealed a Staff Assessment of Mental Status score of 3 which indicated Resident #112 was severely cognitively impaired. Review of the Functional Status revealed that Resident #112 required extensive 1 person assistance for bed mobility and toileting, total dependence of 2 persons for transferring, and total dependence of 1 person for dressing, eating, and personal hygiene. Review of Section M Skin Conditions revealed Resident #112 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an observation on 3/13/2020 at 1:30 P.M. Resident #112's left gluteal fold had a small open area approximately the size of a dime. (Observed with CNA BB). Review of Resident #112's Progress Notes revealed no documentation that the physician was notified of the pressure sore. Resident #123 Review of a Face Sheet revealed Resident #123 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #123, with a reference date of 2/10/20 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated Resident #123 was severely cognitively impaired. Review of the Functional Status revealed that Resident #123 required extensive 1 person assist for bed mobility, dressing, toileting, and personal hygiene and extensive 2 person assistance with transferring. Review of Section M Skin Conditions revealed Resident #123 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an observation on 03/13/2020 at 1:45 P.M. Resident #123's right gluteal fold was noted to have an open area approximately 3cm length x 1cm width. Resident #123's left gluteal fold had a small open area less than 1cm x 1cm. When the CNA BB was performing perineal care Resident #123 loudly exclaimed Ouch! [MEDICAL CONDITION] fire. Review of Resident #123's Progress Notes revealed no documentation that the physician was notified of the pressure sore. Resident #124 Review of a Face Sheet revealed Resident #124 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 1/6/20 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #124 was cognitively impaired. Review of the Functional Status revealed that Resident #124 required extensive 1 person assistance with bed mobility, dressing, toileting, and personal hygiene and total dependence of 2 persons for transferring. Review of Section M Skin Conditions revealed Resident #124 was at risk for developing pressure ulcers/injuries and did have a pressure injury at the time of the assessment. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 10/8/19, Section M Skin Conditions revealed, Resident #124 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an observation on 3/13/20 at 2:00 P.M. the entirety of Resident #124's buttocks was a deep purple/red color and was non blanchable. On the right gluteal fold there was a large open bleeding area approximately the size of a AAA battery. (Skin assessment completed with CNA R and CNA Z). Review of Resident #124's Progress Notes revealed no documentation that the physician was notified of the pressure sore. Resident #111 Review of a Face Sheet revealed Resident #111 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #111, with a reference date of 1/2/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #111 was cognitively intact. Review of the Functional Status revealed that Resident #111 required extensive 1 person assistance for bed mobility, dressing, toileting and personal hygiene and total dependence of 2 persons for transferring. Review of Section M Skin Conditions revealed Resident #111 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an interview on 03/12/20 at 2:07 P.M., CNA Y and CNA CC reported that Resident #111 had an open area on her buttocks. During an observation and interview on 03/13/2020 at 1:02 P.M., Resident #111's buttocks had two non-blanchable quarter size areas on the left buttock and the right buttock approximately 4 inches down from the top of the intergluteal cleft. Resident #111 yelled out loudly in pain when the area was cleaned off by the CNA's. Resident #111 reported that she does choose to stay in her seat all day and recognized that it increased her chances of having skin break down. Review of Resident #111's Progress Notes revealed no documentation the physician was notified of the pressure sore. During an interview on 03/05/2020 at 10:01 A.M., CNA Y stated, (Resident #111) was very sick last week. Review of the nurse to nurse report sheet Unit 1 East Resident List on 3/6/20 at 9:08 A.M. revealed, Resident #111 wheezing throughout (indicated Resident had respiratory symptoms). Resident #113 Review of a Face Sheet revealed Resident #113 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/04/2020 at 4:23 P.M., Resident #113 reported that he has had a cold and cough for approximately 2 weeks. Resident #114 Review of a Face Sheet revealed Resident #114 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/05/2020 at 9:45 A.M., LPN PP reported that Resident #114 is congested. Review of Resident # 144's Progress Notes dated 3/5/20 revealed no documentation of respiratory symptoms. Resident #116 Review of a Face Sheet revealed Resident #116 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/06/2020 at 11:44 A.M., Resident #116 reported, I have a cold today. During an interview on 03/06/2020 on 12:30 P.M., Physician XX reported that he was unaware of the symptoms of upper respiratory infections going around the facility. Physician XX was asked if he was aware of Resident #111, #113, #114, and #116 complaining of upper respiratory infections. Physician XX reported he was notified of Resident #109 and Resident #115 which was why he ordered cough medication. Physician XX reported that he would have looked into other residents had he known they had symptoms because of it being flu season and the dangers of elderly becoming ill. Physician XX reported that he did not see any documentation in progress notes or the Physician Communication Form of residents with upper respiratory infection symptoms. During an interview on 03/13/2020 at 2:50 P.M., Physician XX reported that he was unaware of any new or preexisting pressure ulcers in the facility. Physician 'XX reported he would expect to be notified of a pressure ulcer via the Physician Communication Form. Physician XX reported that he would expect the nursing staff to documenting any irregularities regarding pressure ulcers or any skin breakdown in the Electronic Health Record (EHR). During an interview on 03/13/2020 at 2:50 P.M., Medical Records (MR) K reported that there were no other skin assessments to be scanned into the EHR for Resident #111, #112, #123, or #124. MR K stated, the ones (skin assessments) in the computer (EHR) are the most up to date available. Review of the (Name Omitted) Specialists form (also known as the Physician Communication Form) revealed no entries from the 100 Unit or the 200 Unit regarding pressure ulcers/skin breakdown.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 269 Based on interview and record review, the facility failed to provide an environment free from abuse in 1 of 25 sampled residents (Resident #108) reviewed for abuse, resulting in the potential for a decline in physical, mental, and psychosocial well-being. Findings include: Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property last revised 2018 revealed, (Facility) Rehabilitation & Skilled Nursing will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident property. It is the centers policy to investigate all alleged violations involving Abuse, Neglect, Exploitation,

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Mistreatment of [REDACTED].of Resident Property, including injuries of Unknown Source, in accordance with this policy. Center staff should immediately report all such allegations to the Administrator, Abuse Coordinator, and to the State Reporting Agency in accordance with the procedures in this policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with (facility) Rehabilitation & Skilled Nursing's crime reporting policy .C. Prevention & Identification (facility) procedures will include: 1. An analysis of the physical environment that may make Abuse, Neglect, Exploitation of residents, or Misappropriation of Resident Property more likely to occur, such as secluded areas of the center; 2. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs; For purposes of this policy, staff members include employees, consultants, contractors, volunteers and any other caregivers who provide care and services to residents on behalf of the center. c. If a third party is accused or suspected. If a person not on staff is accused of Abuse, Neglect, Exploitation, Mistreatment of [REDACTED].Property, (facility) will take action to protect the resident including, but not limited to, contacting the third party and addressing the issue directly with him/her, preventing access to resident during the investigation, and/or referring the matter to the appropriate authorities. d. Notify Social Services. If appropriate, the social services department should be notified of the incident so that it may take appropriate interventions to care for the psychosocial needs of any involved resident. e. Notify Resident Representative and Physician. The Resident Representative, and the resident's attending physician, if appropriate, should be notified of the incident. Document. Documentation in the incident report should include the result of the resident's assessment, notification of the physician and the Resident Representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. E. Initial Report 1. Timing. A. Administrator. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of [REDACTED]. b. State Agency. If abuse or Serious Bodily Injury is alleged. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the State Agency immediately, but not later than two (2) hours after the allegation is made. All Other Allegations. The Administrator or his/her designee will notify the State Agency of all alleged violations involving Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member. 2. Administrator. The Administrator should be notified by informing him/her in person, calling via telephone, or other forms of communication deemed appropriate by the Administrator. 3. State Agen4 Report incident/allegation following protocol set forth by the center's specific State Agency. 4. Suspected Crimes. If (facility) suspects that a crime has been committed it will report that suspicion in accordance with its crime reporting policy. Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 12/5/19 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #108 was cognitively intact. Review of the Functional Status revealed that Resident #108 required extensive 1 person assistance for bed mobility and personal hygiene, total dependence of 2 persons for toileting and transferring, and total dependence of 1 person for eating and dressing. Review of the medical record for Resident #108 revealed no documentation of behavioral issues including resisting care. Review of the facility Resident Council Minutes dated 1/14/20 revealed, CNA (Certified Nursing Assistant HH) rough w/ (with) everyone (Resident #108 does not want on his hall.) During an interview on 03/13/2020 at 8:45 A.M., Resident #108's Guardian/Family Member (FM) M reported that a CNA HH had performed rough care on Resident #108 on night shift. FM M reported that she had not been notified of follow up from the incident. FM M reported that Resident #108 had [MEDICAL CONDITION] and he could not do anything for himself. FM M reported she (FM M) removed Resident #108 from the facility because of the care he was receiving at the facility. During an interview on 03/04/2020 at 3:36 P.M., Licensed Practical Nurse (LPN) LL reported that residents had made complaints of CNA HH this summer/fall and the Director of Nursing (DON) was made aware at that time. LPN LL reported that she was not aware of any investigations into CNA HH's behaviors with residents. During an interview on 3/05/2020 at 1:32 P.M., CNA HH reported that she was fired on 2/14/20. CNA HH reported that she had attempted to care for Resident #108 one night and he was not compliant with care. CNA HH reported that when she returned for her next shift (following the night she attempted to care for Resident #108) she found out he had a complaint against her. CNA HH reported she was put on suspension for the incident and when she was called back to work she was terminated. CNA HH reported that there was no investigation and they did not speak to her about the allegation or to other staff that worked with her on that shift. CNA HH reported she knows this was considered a reportable incident because of the allegations of abuse made against her. Review of CNA HH revealed a Disciplinary Action Form dated 2/12/20, Termination .Employee violated #15 on conduct & behavior policy in regards to her care for and with residents .This is unacceptable behavior and conduct from the weekend of 2/8/20-2/9/20. Resident complaints of taking over an hour to answer call lights-Resident complaints of employee being rude to them including making grunting noises instead of answering-Employee was moved halls over the weekend and more complaints of performance were received from new section .Due to severity and nature of violations, we are terminating employment at this time. An interoffice email (in employee file) dated 2/12/20 revealed, Please try to work in all these point on the Term (termination) for (CNA HH). Resident complaints about taking over 1 hour to answer call lights. This is unacceptable and has no reasonable explanation. This creates an unsafe environment for our residents. Customer service is number one at (facility). Resident complaints about employee being rude to them. One resident states CNA makes grunting noise instead of answering them when they ask her questions. This fall under #15 rude or discourteous behavior which can itself result in termination. CNA was moved halls over the weekend and more complaints about performance were received from the new section. Nurse complaints of employee always having a negative attitude and not taking direction well. CNA has been observed with negative facial expressions often on duty. Again this is a violation of company policy.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 269 Based on interview and record review, the facility failed to immediately report abuse to the State Agency and report investigation results to the State Agency within 5 working days for 1 out of 25 sampled residents (Resident #108) reviewed for abuse reporting, resulting in the potential for continued violations involving mistreatment, neglect, or abuse going undetected, unreported, or without thorough investigation. Findings include: Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property last revised 2018 revealed, (Facility) Rehabilitation & Skilled Nursing will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident property. It is the centers policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of [REDACTED].of Resident Property, including injuries of Unknown Source, in accordance with this policy. Center staff should immediately report all such allegations to the Administrator, Abuse Coordinator, and to the State Reporting Agency in accordance with the procedures in this policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with (facility) Rehabilitation & Skilled Nursing's crime reporting policy .C. Prevention & Identification (facility) procedures will include: 1. An analysis of the physical environment that may make Abuse, Neglect, Exploitation of residents, or Misappropriation of Resident Property more likely to occur, such as secluded areas of the center; 2. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs; For purposes of this policy, staff members include employees, consultants, contractors, volunteers and any other caregivers who provide care and services to residents on behalf of the center. c. If a third party is accused or suspected. If a person not on staff is accused of Abuse, Neglect, Exploitation, Mistreatment of [REDACTED].Property, (facility) will take action to protect the resident including, but not limited to, contacting the third party and addressing the issue directly with him/her, preventing access to resident during the investigation, and/or referring the matter to the appropriate authorities. d. Notify Social Services. If appropriate, the social services department should be notified of the incident so that it may take appropriate interventions to care for the psychosocial needs of any involved resident. e. Notify Resident Representative and Physician. The Resident Representative, and the resident's attending physician, if appropriate, should be notified of the incident. Document. Documentation in the incident report should include the result of the resident's assessment, notification of the physician and the Resident Representative, and any

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) treatment provided. Appropriate quality assurance documentation should be completed as well. E. Initial Report 1. Timing. A. Administrator. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of [REDACTED]. b. State Agency. If abuse or Serious Bodily Injury is alleged. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the State Agency immediately, but not later than two (2) hours after the allegation is made. All Other Allegations. The Administrator or his/her designee will notify the State Agency of all alleged violations involving Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member. 2. Administrator. The Administrator should be notified by informing him/her in person, calling via telephone, or other forms of communication deemed appropriate by the Administrator. 3. State Agen4 Report incident/allegation following protocol set forth by the center's specific State Agency. 4. Suspected Crimes. If (facility) suspects that a crime has been committed it will report that suspicion in accordance with its crime reporting policy. Resident #108 Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of the medical record for Resident #108 revealed no documentation of behavioral issues including resisting care. Review of the facility Resident Council Minutes dated 1/14/20 revealed, CNA (Certified Nursing Assistant HH) rough w/ (with) everyone (Resident #108 does not want on his hall.) During an interview on 03/04/2020 at 3:36 P.M., Licensed Practical Nurse (LPN) LL reported that residents had made complaints of CNA HH this summer/fall and the Director of Nursing (DON) was made aware at that time. LPN LL reported that she was not aware of any investigations into CNA HH's behaviors with residents. During an interview on 3/05/2020 at 1:32 P.M., CNA HH reported that she was fired on 2/14/20. CNA HH reported that she had attempted to care for Resident #108 one night and he was not compliant with care. CNA HH reported that when she returned for her next shift (following the night she attempted to care for Resident #108) she found out he had a complaint against her. CNA HH reported she was put on suspension for the incident and when she was called back to work she was terminated. CNA HH reported that there was no investigation and they did not speak to her about the allegation or to other staff that worked with her on that shift. CNA HH reported she knows this was considered a reportable incident because of the allegations of abuse made against her. Review of CNA HH revealed a Disciplinary Action Form dated 2/12/20, Termination .Employee violated #15 on conduct & behavior policy in regards to her care for and with residents .This is unacceptable behavior and conduct from the weekend of 2/8/20-2/9/20. Resident complaints of taking over an hour to answer call lights-Resident complaints of employee being rude to them including making grunting noises instead of answering-Employee was moved halls over the weekend and more complaints of performance were received from new section .Due to severity and nature of violations, we are terminating employment at this time. An interoffice email (in employee file) dated 2/12/20 revealed, Please try to work in all these point on the Term (termination) for (CNA HH). Resident complaints about taking over 1 hour to answer call lights. This is unacceptable and has no reasonable explanation. This creates an unsafe environment for our residents. Customer service is number one at (facility). Resident complaints about employee being rude to them. One resident states CNA makes grunting noise instead of answering them when they ask her questions. This fall under #15 rude or discourteous behavior which can itself result in termination. CNA was moved halls over the weekend and more complaints about performance were received from the new section. Nurse complaints of employee always having a negative attitude and not taking direction well. CNA has been observed with negative facial expressions often on duty. Again this is a violation of company policy. During an interview on 03/05/2020 at 1:32 P.M., Administrator A reported that had he been aware of the allegation against CNA HH he would have expected staff to report the allegation, an investigation would have been started, and it would have been reported to the State Agency if warranted. During an interview on 03/11/2020 at 11:01 A.M., Registered Nurse (RN) NN reported that she is unsure who staff are to report abuse to at this time because of the changeover of upper administration.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 269 Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse and neglect for 1 of 25 sampled residents (Resident #108) reviewed for abuse investigations resulting in (A) the potential for further abuse and neglect to occur and (B) the potential for incorrect results of an investigation which could lead to ineffective corrective actions. Findings include: Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property last revised 2018 revealed, (Facility) Rehabilitation & Skilled Nursing will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident property. It is the centers policy to investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of [REDACTED].of Resident Property, including injuries of Unknown Source, in accordance with this policy. Center staff should immediately report all such allegations to the Administrator, Abuse Coordinator, and to the State Reporting Agency in accordance with the procedures in this policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with (facility) Rehabilitation & Skilled Nursing's crime reporting policy .C. Prevention & Identification (facility) procedures will include: 1. An analysis of the physical environment that may make Abuse, Neglect, Exploitation of residents, or Misappropriation of Resident Property more likely to occur, such as secluded areas of the center; 2. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs; For purposes of this policy, staff members include employees, consultants, contractors, volunteers and any other caregivers who provide care and services to residents on behalf of the center. c. If a third party is accused or suspected. If a person not on staff is accused of Abuse, Neglect, Exploitation, Mistreatment of [REDACTED].Property, (facility) will take action to protect the resident including, but not limited to, contacting the third party and addressing the issue directly with him/her, preventing access to resident during the investigation, and/or referring the matter to the appropriate authorities. d. Notify Social Services. If appropriate, the social services department should be notified of the incident so that it may take appropriate interventions to care for the psychosocial needs of any involved resident. e. Notify Resident Representative and Physician. The Resident Representative, and the resident's attending physician, if appropriate, should be notified of the incident. Document. Documentation in the incident report should include the result of the resident's assessment, notification of the physician and the Resident Representative, and any treatment provided. Appropriate quality assurance documentation should be completed as well. E. Initial Report 1. Timing. A. Administrator. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of [REDACTED]. b. State Agency. If abuse or Serious Bodily Injury is alleged. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the State Agency immediately, but not later than two (2) hours after the allegation is made. All Other Allegations. The Administrator or his/her designee will notify the State Agency of all alleged violations involving Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Injuries of Unknown Source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member. 2. Administrator. The Administrator should be notified by informing him/her in person, calling via telephone, or other forms of communication deemed appropriate by the Administrator. 3. State Agen4 Report incident/allegation following protocol set forth by the center's specific State Agency. 4. Suspected Crimes. If (facility) suspects that a crime has been committed it will report that suspicion in accordance with its crime reporting policy. Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 12/5/19 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #108 was cognitively intact. Review of the Functional Status revealed that Resident #108 required extensive 1 person assistance for bed mobility and personal hygiene, total dependence of 2 persons for toileting and transferring, and total dependence of 1 person for eating and dressing. Review of the medical record for Resident #108 revealed no documentation of behavioral issues including resisting care. Review of the facility Resident Council Minutes dated 1/14/20 revealed, CNA (Certified Nursing Assistant HH) rough w/ (with) everyone (Resident #108 does not want on his hall.) During an interview on 03/13/2020 at 8:45 A.M., Resident #108's Guardian/Family Member (FM) M reported that a CAN HH had performed rough care on Resident #108 on night shift. FM M reported that she had not been notified of follow up from the incident. FM M reported that Resident #108 had [MEDICAL CONDITION] and he could not do anything for himself. FM M reported she (FM M) removed Resident #108 from the facility because of the care he was receiving at the facility. During an interview on 03/04/2020 at 3:36 P.M., Licensed Practical Nurse (LPN) LL reported that residents had made complaints of CNA HH this summer/fall and the Director of Nursing (DON) was made aware at that time. LPN LL reported that she was not aware of any investigations into CNA HH's behaviors

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACEWAY AT COUNTRYSIDE	120 BASELINE RD SOUTH HAVEN, MI 49090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) with residents. During an interview on 3/05/2020 at 1:32 P.M., CNA HH reported that she was fired on 2/14/20. CNA HH reported that she had attempted to care for Resident #108 one night and he was not compliant with care. CNA HH reported that when she returned for her next shift (following the night she attempted to care for Resident #108) she found out he had a complaint against her. CNA HH reported she was put on suspension for the incident and when she was called back to work she was terminated. CNA HH reported that there was no investigation and they did not speak to her about the allegation or to other staff that worked with her on that shift. CNA HH reported she knows this was considered a reportable incident because of the allegations of abuse made against her. Review of CNA HH revealed a Disciplinary Action Form dated 2/12/20, Termination .Employee violated #15 on conduct & behavior policy in regards to her care for and with residents .This is unacceptable behavior and conduct from the weekend of 2/8/20-2/9/20. Resident complaints of taking over an hour to answer call lights-Resident complaints of employee being rude to them including making grunting noises instead of answering-Employee was moved halls over the weekend and more complaints of performance were received from new section .Due to severity and nature of violations, we are terminating employment at this time. An interoffice email (in employee file) dated 2/12/20 revealed, Please try to work in all these point on the Term (termination) for (CNA HH). Resident complaints about taking over 1 hour to answer call lights. This is unacceptable and has no reasonable explanation. This creates an unsafe environment for our residents. Customer service is number one at (facility). Resident complaints about employee being rude to them. One resident states CNA makes grunting noise instead of answering them when they ask her questions. This fall under #15 rude or discourteous behavior which can itself result in termination. CNA was moved halls over the weekend and more complaints about performance were received from the new section. Nurse complaints of employee always having a negative attitude and not taking direction well. CNA has been observed with negative facial expressions often on duty. Again this is a violation of company policy. During an interview on 03/05/2020 at 12:14 P.M., CNA FF reported that investigation into allegations of abuse are a load of crap. When it comes to investigating and talking to people they (administration) just make things go away when they don't want to deal with it. During an interview on 03/05/2020 at 12:16 P.M., CNA GG reported that she would ride to work with CNA FF because she could not drive. CNA GG reported that CNA FF was put on suspension for an allegation of abuse. CNA GG reported that she called the DON at the time and told her she would not be able to make it to work because she did not have a ride with CNA FF. CNA GG stated that the DON at the time unsuspended her to make sure I got to work. During an interview on 03/05/2020 at 1:32 P.M., Administrator A reported that had he been aware of the allegation against CNA HH he would have expected staff to report the allegation, an investigation would have been started, and it would have been reported to the State Agency if warranted. Review of Facility Reported Incidents revealed no investigation into the allegation that was made against CNA HH.Review of Facility Reported Incidents revealed no investigation into the allegation that was made against CNA HH.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 285 Based on observation, interview, and record review, the facility failed to follow professional standards of nursing practice for medication preparation and administration (preset medications), for 1 of 25 residents reviewed for administration of medication, resulting in the potential for the wrong medication being administered to a resident and/or misappropriation of medications. Findings include: Review of the facility policy Storage of Medications last revised January 2019 revealed, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. During an observation on 03/05/2020 at 1:39 P.M., the 200 Unit Medication Cart was outside of room [ROOM NUMBER] with no staff present visible. The 200 Unit Medication Cart had 6 medication cups on top of the cart. Each medication cup contained 1-2 medications without resident names on the cups. No names or room numbers were observed on the medication cups to indicate which residents the medication cups were for. During an interview on 03/05/2020 at 4:21 P.M., Licensed Practical Nurse (LPN) JJ reported that medications should never be preset and medications should never be left unattended on the top of the Medication Cart.
F 0686 **Level of harm** - 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 #MI 637 Based on observation, interview, and record review, the facility failed to prevent facility acquired pressure ulcers and provide pressure ulcer preventative care consistent with professional standards of practice (reposition residents at risk, follow policy for Braden Skin Assessments, update care plans, follow treatment orders, wound management, and measuring pressure ulcers) for 6 out of 25 residents (Resident #110, #112, #123, #124, #108, and #111) reviewed for the risk of and/or the development of pressure injuries, resulting in the development of an avoidable pressure ulcer and the potential for skin breakdown and overall deterioration in health status. Findings include: Review of the facility policy Skin Practice Guidelines last revised on 12/23/19 revealed, PURPOSE: To describe the process steps for identification of patients at risk for the development of pressure ulcers, identify prevention techniques and interventions to assist with the management of pressure ulcers and skin alterations .PREVENTION INTERVENTIONS: Reposition frequently in bed and chair-Rehabilitation team consultations-Barrier cream products-Manage continence with toileting programs-Use patient positioning device to reduce friction and shear-Honor food preferences, offer alternatives-Encourage adequate nutrition and hydration-Elevate heels- Select appropriate support surfaces-Complete thorough skin observations .After completion of the initial plan of care, the patient Kardex and Task List are updated. The Weekly Skin Alteration Assessment in (electronic health record) is completed by the licensed nurse for those patients identified as at risk for skin breakdown. The assessment is completed weekly and identifies the progression of existing skin alterations as well as identifying new areas of concern. Daily body audits are completed by licensed nurses for those patients with existing pressure ulcers .Weekly skin alteration evaluations are completed by the licensed nurse for those wounds not being evaluated by the wound team (e.g., skin tears, surgical incisions, rashes, etc.) The findings are documented on the Weekly Skin Alteration Assessment located in (electronic health record) .BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK-The Braden Scale is a clinically validated tool widely used to identify potential levels of risk for pressure ulcer development. Each patient is evaluated upon admission .quarterly, with a significant change, and as clinically indicated .The Braden Scale for Predicting Pressure Sore Risk: - Aids in clinical decision making-the use of a clinically standardized validated risk assessment tool helps to direct the process by which clinicians identify those at risk and quantify the level of identified risk. - Allows the selective targeting of preventive interventions and assists in resource identification so that resources can be targeted to match the risk. Facilitates care planning to focus on the specific dimensions that place the patient at greatest risk. Overall, Braden Scale scored provide data on general pressure ulcer risk and assist clinicians to plan care according to the amount of risk (very high, high, moderate, low) .WOUND MANAGEMENT TEAM .The wound management team re-evaluates pressure ulcers and complex wounds weekly . Review of the facility policy Rounds last revised 2018 revealed, Purpose: To provide a method that assists the user to monitor and observe systems or processes related to clinical, administrative or environmental areas. Guidelines .Clinical: Changes in patient condition, observation of care techniques, observation of care plan provision, effectiveness of care plan approaches, identification of educational opportunities, infection control. Review of Fundamentals of Nursing (Potter and Perry) 8th edition revealed, Positioning interventions reduce pressure and shearing force to the skin. Elevating the head of the bed to 30 degrees or less decreases the chance of pressure ulcer development from shearing forces .patient's need repositioning on a schedule of at least every 2 hours .Some patients are able to sit in a chair. Make sure to limit the total amount of time they sit to 2 hours or less. Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 1196-1197 Review of Fundamentals of Nursing (Potter and Perry) 9th edition revealed, Nonblanchable [DIAGNOSES REDACTED] is visible skin redness that persists with the application of pressure. It indicates structural damage to the capillary bed/ microcirculation. This is an indication for a category/ stage I pressure ulcer. Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing - E-Book (Kindle Locations -). Elsevier Health Sciences. Kindle Edition. Resident #110 Review of a Face Sheet revealed Resident #110 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 1/20/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #110 was cognitively intact. Review of the Functional Status revealed that Resident #110 required extensive 1 person assist for bed mobility, dressing, toileting, and personal hygiene and extensive 2 person assistance for transferring. Review of Section M Skin Conditions revealed Resident #110 was at risk for developing pressure

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) ulcers/injuries and did not have a pressure injury at the time of the assessment. Review of Resident #110's Braden Scale for Predicting Pressure Sore Risk dated 11/13/19 revealed a score of 14 which indicated a moderate risk. Review of Resident #110's Care Plan revealed, Risk for Impaired Skin Integrity R/T (related to) admitted with pressure ulcer to left buttock (resolved), [MEDICAL CONDITION], Left sided [MEDICAL CONDITION], weakness, incontinence, [MEDICAL CONDITION], poor oral intake. I will refuse to reposition and stay off my buttocks. I will also remove foot Pillows. shearing to right side of back resolved red areas to outer left foot (Resident #110) will remove boot at times 2/4/20 bilat (bilateral) buttocks, mid back open areas Date Initiated: 10/16/2019 Revision on: 02/12/2020 The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. Date Initiated: 10/16/2019 Revision on: 10/18/2019 Target Date: 05/03/2020 - foot boot to left foot as he will allow Date Initiated: 01/02/2020 Monitor labs. Date Initiated: 10/16/2019 Monitor Resident's nutritional intake Date Initiated: 10/16/2019 Provide incontinent care after each incontinent episode. Date Initiated: 10/16/2019 Treatments per MD order. Date Initiated: 10/16/2019 Revision on: 10/18/2019 Utilize pressure relieving devices on appropriate surfaces. During an interview on 03/12/2020 at 10:50 A.M., Certified Nursing Assistant (CNA) T reported that Resident #110 does not complain when being repositioned and is cooperative with care. Review of Resident #110's Behavior Log from the last 30 days revealed no documentation of behaviors (including rejection of care.) During an interview on 03/04/2020 at 3:36 P.M., LPN LL reported that Resident #110 had a pressure ulcer on his back and his buttocks. During an observation on 03/05/2020 at 8:38 A.M., Resident #110 was in his geri-chair on his back. The head of the geri-chair was noted to be raised to approximately 30 degrees. During an observation on 03/05/2020 at 9:24 A.M., Resident #110 was in his bed on his back. Resodemt #108 was noted to not have a pillow behind his left or right side to offload pressure. During an observation on 03/05/2020 at 10:14 A.M., Resident #110 was in his bed on his back. Resodemt #108 was noted to not have a pillow behind his left or right side to offload pressure. During an observation on 03/05/2020 at 11:36 A.M., Resident #110 was in his bed on his back. Resodemt #108 was noted to not have a pillow behind his left or right side to offload pressure. During an observation on 03/05/2020 at 1:38 P.M., Resident #110 was in his bed on his back. Resodemt #108 was noted to not have a pillow behind his left or right side to offload pressure. Review of Resident #110's March 2020 Treatment Administration Order (TAR) revealed, Skin assessment to be done on shower days every evening shift every Mon, Fri for Skin assessment -Start Date-01/03/2020. Review of Resident #110's Weekly Skin Alteration assessment dated [DATE] revealed, pressure sore .Vertebrae (upper-mid) 1 (cm) x 2 (cm) .Right iliac crest (rear) 1 (cm) x 1 (cm) .Left Buttock 1 (cm) x 1 (cm). Review of Resident #110's Weekly Skin Alteration assessment dated [DATE] revealed, Right Gluteal Fold .Treatment in place on buttock. During an observation on 03/12/2020 at 8:57 A.M., Resident #110 had a bandage on the left side of his buttock. Resident #110's right buttock skin was noted to be (surrounding the bandage) deep purple/red and it was non blanchable. The bandage was dated 3/11 with no time written on the bandage. CNA T was present during the observation. During an observation on 03/13/2020 at 12:16 P.M., Resident #110's bandage was removed by LPN JJ. Resident #110's bilateral buttocks was noted to be deep purple/red and it was non blanchable. Resident #112 Review of a Face Sheet revealed Resident #112 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #112, with a reference date of 2/20/20 revealed a Staff Assessment of Mental Status score of 3 which indicated Resident #112 was severely cognitively impaired. Review of the Functional Status revealed that Resident #112 required extensive 1 person assistance for bed mobility and toileting, total dependence of 2 persons for transferring, and total dependence of 1 person for dressing, eating, and personal hygiene. Review of Section M Skin Conditions revealed Resident #112 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. Review of Resident #112's Braden Scale for Predicting Pressure Sore Risk dated 8/18/19 revealed a score of 12 which indicated high risk. Review of Resident #112's Care Plan revealed, (Resident #112) experiences incontinence r/t Alzheimer's, limited mobility, impaired communication skills. Date Initiated: 01/01/2019 Revision on: 01/25/2019 (Resident #112) will remain free from skin breakdown due to incontinence and brief use through the review date. Date Initiated: 01/01/2019 Revision on: 01/25/2019 Target Date: 03/29/2020 .INCONTINENT: Check and change every two hours and as required for incontinence . Review of Resident #112's Care Plan revealed, (Resident #112) has actual skin breakdown .9/20/2019 left second toe ulcer Date Initiated: 01/01/2019 Revision on: 09/23/2019. During an interview on 03/12/20 at 2:07 P.M., CNA Y and CNA CC reported that Resident #112 had an open area on her buttocks. During an observation on 03/12/2020 at 8:22 A.M., Resident #112 was sitting up in her geri-chair with the head of her geri-chair at approximately 35 degrees. During an observation on 03/12/2020 at 9:39 A.M., Resident #112 was sitting up in her geri-chair with the head of her geri-chair at approximately 35 degrees. During an observation on 03/12/2020 at 10:38 A.M., Resident #112 was sitting up in her geri-chair with the head of her geri-chair at approximately 35 degrees. During an observation on 03/12/2020 at 11:49 A.M., Resident #112 was sitting up in her geri-chair with the head of her geri-chair at approximately 35 degrees. Review of Resident #112's Physician Orders revealed, skin assessment every day shift every Tue, Thu for skin monitoring Active 8/27/2019. Review of Resident #112's Weekly Skin Alteration assessment dated [DATE] revealed, No new skin issues at this time. Review of Resident #112's Weekly Skin Alteration assessment dated [DATE] revealed, Coccyx slightly pink no further skin issues at this time. Review of Resident #112's Weekly Skin Alteration assessment dated [DATE] revealed, Coccyx (description) redness observed to coccyx. (Name omitted) ointment applied for protection. Review of Resident #112's Weekly Skin Alteration Assessment reviewed prior to exit on 3/13/20 and was not completed. During an observation on 3/13/2020 at 1:30 P.M. Resident # 112's left gluteal fold had a small open area approximately the size of a dime. CNA BB was present at the time of the observation. Resident #123 Review of a Face Sheet revealed Resident #123 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #123, with a reference date of 2/10/20 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated Resident #123 was severely cognitively impaired. Review of the Functional Status revealed that Resident #123 required extensive 1 person assist for bed mobility, dressing, toileting, and personal hygiene and extensive 2 person assistance with transferring. Review of Section M Skin Conditions revealed Resident #123 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. Review of Resident #123's Braden Scale for Predicting Pressure Sore Risk dated 7/30/19 revealed a score of 12 which indicated high risk. Review of Resident #123's Care Plan revealed, (Resident #123) is at risk for Impaired Skin Integrity r/t [MEDICAL CONDITIONS], DM (diabetes), Delusional disorder, Anxiety, incontinence, non-ambulatory, limited mobility. (Resident #123) noted to be picking at skin causing open areas bilateral arms. Date Initiated: 01/12/2019 Revision on: 02/25/2019 (Resident #123) skin will remain intact. Date Initiated: 01/12/2019 Target Date: 03/28/2020 Conduct a systematic skin inspection weekly. Pay particular attention to body prominence. CNA to observe with daily cares. Date Initiated: 01/12/2019 Revision on: 04/01/2019 Review of Resident #123's Physician Orders revealed, weekly skin assessment on shower days every day shift every Mon, Thu for skin assessment Active 8/26/2019. Review of Resident #123's Weekly Skin Alteration assessment dated [DATE] revealed, Right Knee (front) (Description) Bruise. Review of Resident #123's Weekly Skin Alteration assessment dated [DATE] revealed, Sacrum (Description) redness. Review of Resident #123's Weekly Skin Alteration assessment dated [DATE] revealed, Coccyx (Description) redness. Review of Resident #123's Weekly Skin Alteration Assessment reviewed prior to the exit from the facilty on 3/13/20 and was not completed. During an observation on 03/13/2020 at 1:45 P.M. Resident #123's right gluteal fold had an open area approximately 3cm length x 1cm width. Resident #123's left gluteal fold had a small open area less than 1cm x 1cm. When CNA BB was performing perineal care Resident #123 loudly exclaimed Ouch! [MEDICAL CONDITION] fire. Resident #124 Review of a Face Sheet revealed Resident #124 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 1/6/20 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #124 was cognitively impaired. Review of the Functional Status revealed that Resident #124 required extensive 1 person assistance with bed mobility, dressing, toileting, and personal hygiene and total dependence of 2 persons for transferring. Review of Section M Skin Conditions revealed Resident #124 was at risk for developing pressure ulcers/injuries and did have a pressure injury at the time of the assessment. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 10/8/19, Section M Skin Conditions revealed, Resident #124 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. Review of Resident #124's Braden Scale for Predicting Pressure Sore Risk dated 4/25/19 revealed a score of 13 which indicated moderate risk. Review of Resident #124's Care Plan revealed, I have actual skin breakdown r/t non ambulatory, limited mobility, obesity, OA [MEDICAL CONDITIONS] ([MEDICAL CONDITION]), incontinent, abnormal labs and HX (history) skin integrity issues. I refuse to reposition off my buttocks. Fragile healed scared (sic) tissues to coccyx, open area to r buttock masd (Moisture

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235573	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACEWAY AT COUNTRYSIDE	120 BASELINE RD SOUTH HAVEN, MI 49090

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) Associated Skin Damage) 8/21/2019 left buttock and sacrum 8/29/2019 resolved 9/14/19 vascular blister to back of r knee RESOLVED PIN POINT AREAS TO R BUTTOCK CONT resolved 1/7/2020 1 area to l buttock 2 areas to r buttock Scab to left foot great toe and second toe. Date Initiated: 01/07/2019 Revision on: 03/09/2020 My skin issues will heal without complications. Date Initiated: 01/07/2019 Revision on: 08/26/2019 Target Date: 05/14/2020 Turn and reposition q 2 hours and PRN including elevation of heels as she will allow. Date Initiated: 01/07/2019 Revision on: 04/24/2019 tx as ordered Date Initiated: 08/21/2019. Review of Resident #124's Behavior Log from the last 30 days revealed no documentation of behaviors (including rejection of care.) Review of Resident #124's Physician Order revealed, Skin assessments done on shower days every day shift every Mon, Thu Active 7/4/2019. Review of Resident #124's Weekly Skin Alteration assessment dated [DATE] revealed, Right buttock (Description) excoriation. Left buttock (Description) excoriation. (This documentation was in progress and not complete) Review of Resident #124's Weekly Skin Alteration assessment dated [DATE] revealed, Right buttock (Description) redness. Left buttock (Description) redness. (This documentation was in progress and not complete) Review of Resident #124's Weekly Skin Alteration assessment dated [DATE] revealed, no new issues. Review of Resident #124's Weekly Skin Alteration Assessment reviewed prior to exit on 3/13/20 and was not completed. Review of a sign hanging above Resident #124's bed revealed, Turn only to left/right side every 2 hours. Do not put on her back. During an observation on 3/13/20 at 2:00 P.M. the entirety of Resident #124's buttocks was a deep purple/red color and was non blanchable. On the right gluteal fold there was a large open bleeding area approximately 1cm x 3cm. During an interview on 3/13/2020 at 1:40 P.M., Confidential Staff Member (CSM) MMM reported that Resident #124 is not repositioned every 2 hours as ordered because there is not enough staff. Resident #108 Review of a Face Sheet revealed Resident #108 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Resident #108 no longer resided in the facility. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 12/5/19 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #108 was cognitively intact. Review of the Functional Status revealed that Resident #108 required extensive 1 person assistance for bed mobility and personal hygiene, total dependence of 2 persons for toileting and transferring, and total dependence of 1 person for eating and dressing. Review of Section M Skin Conditions revealed Resident #108 was at risk for developing pressure ulcers/injuries and did have a pressure injury at the time of the assessment. Review of Resident #108's Braden Scale for Predicting Pressure Sore Risk dated 12/11/19 revealed a score of 15 which indicated at risk. During an interview on 03/13/2020 at 8:45 A.M., Family Member (FM) M reported that Resident #108 suffered from a bed sore he got while at the facility 1 year ago. FM M reported they were not bathing him and cleaning him up like they should have. FM M reported that Resident #108 needed to be repositioned because of his physical condition and they did not have enough staff to reposition him .They never had time. FM M stated, This past year he got to where he wouldn't smile. (Resident #108) was down (depressed) and grouchy. His whole demeanor changed since he left and he is smiling again. FM M reported that Resident #108 at [MEDICAL CONDITION] and required extensive assistance with care. FM M reported that Resident #108 would call FM M at 2 to 3 A.M. and would ask me to call the facility because his call light was on and no one was responding. I would call and it would ring and ring and ring. (which indicated no staff members were answering the telephone) Review of Resident #108's Care Plan revealed, (Resident #108) is at risk for Impaired Skin Integrity r/t [MEDICAL CONDITIONS], Chronic pain, non-ambulatory, limited mobility. Refusals/noncompliance with turning and repositioning, gets up between 5-5:30am. He is very particular about his care givers and often declines care from some, especially older CNA;S and nurses. He will often wait days for a particular care giver to take care of him. He has a hx of a stage III pressure ulcer to left buttock which is now open Date Initiated: 01/12/2019 Revision on: 01/17/2020 (Resident #108) will develop not further skin breakdown. Date Initiated: 01/12/2019 Target Date: 03/29/2020 Pressure reduction mattress. Date Initiated: 01/12/2019 Revision on: 03/26/2019 alternate manual w/c (wheelchair) and power chair daily Date Initiated: 01/28/2020 Assist with meals as needed. Date Initiated: 01/16/2019 Consult a dietician per order Date Initiated: 01/12/2019 Encourage oral intake to promote good nutrition for skin integrity. Date Initiated: 01/12/2019 Ensure nails are clipped Date Initiated: 01/12/2019 Labs as order. Date Initiated: 01/12/2019 Maintain HOB (head of bead) at lowest elevation tolerated. Date Initiated: 01/12/2019 Revision on: 04/22/2019 Pressure reduction cushion to wheelchair. Date Initiated: 01/12/2019 Pro heal BID (twice a day) to promote wound healing. Date Initiated: 03/26/2019 Report any signs of skin breakdown sore, tender, red or broken skin. Date Initiated: 01/12/2019 Treatment to left buttock per MD order. Date Initiated: 01/12/2019 Turn and reposition every two hours and PRN including elevation of heels as he will allow. Date Initiated: 01/12/2019. (sic) Review of Resident #108's Kardex (brief overview of residents needs) revealed, BED MOBILITY: (Resident #108) is totally dependent on two staff for repositioning and turning in bed every two hours and PRN including elevation of heels as he will allow. Review of Resident #108's Weekly Skin Alteration assessment dated [DATE] revealed, Groin . (Documentation) Reddened area. Review of Resident #108's Behavior Log from February 18th to his discharge revealed no documentation of behaviors (including 'rejection of care) Resident #111 Review of a Face Sheet revealed Resident #111 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #111, with a reference date of 1/2/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #111 was cognitively intact. Review of the Functional Status revealed that Resident #111 required extensive 1 person assistance for bed mobility, dressing, toileting and personal hygiene and total dependence of 2 persons for transferring. Review of Section M Skin Conditions revealed Resident #111 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. Review of Resident #111's Braden Scale for Predicting Pressure Sore Risk dated 7/24/19 revealed a score of 16 which indicated at risk. Review of Resident #111's Care Plan revealed, I have altered skin Integrity r/t Dementia, DM (diabetes), IBS (irritable bowel syndrome), Weakness, Obesity, incontinence, limited mobility. I will refuse to lie down all day. Date Initiated: 07/03/2019 Revision on: 02/12/2020 Resident's Skin Will Remain Intact residents skin will heal without complications Date Initiated: 07/03/2019 Revision on: 12/02/2019 Target Date: 04/02/2020 skin issues will resolve without complications Date Initiated: 01/29/2020 Target Date: 04/02/2020 .Nurse to conduct a systematic skin inspection weekly. Pay particular attention to the bony prominence. CNA to observe skin integrity with daily cares. Date Initiated: 07/03/2019 Tx as ordered Date Initiated: 01/29/2020 . During an interview on 03/12/20 at 2:07 P.M., CNA Y and CNA CC reported that Resident #111 had an open area on her buttocks. Review of Resident #111's Physician Orders revealed, Skin assessments done on shower days every day shift every Mon, Thu for skin assessment Active 8/26/2019. Review of Resident #111's Weekly Skin Alteration assessment dated [DATE] revealed, Left iliac crest (front) (blank) .Left thigh (front) (description) bruise .Groin (description) red area .Sacrum (Description)open area. No measurements were documented for the skin integrity alterations. Review of Resident #111's Weekly Skin Alteration assessment dated [DATE] revealed, Right shoulder (rear) (Description) (blank) .Left shoulder (rear) (Description) (blank) .Coccyx (Description) (blank) .Groin (Description) (blank). Review of Resident #111's Weekly Skin Alteration assessment dated [DATE] revealed, Right buttock (Description) open area .Left buttock (Description) open area. Review of Resident #111's Weekly Skin Alteration assessment dated [DATE] revealed, Right Shoulder (rear) (Description) skin intact dry scabby area .Left shoulder (rear) (Description) skin intact, dry scabby area .Coccyx (Description) skin intact, dry scabby area. Review of Resident #111's Weekly Skin Alteration assessment dated [DATE] revealed, Coccyx (Description) red .Groin (Description) red. Review of Resident #111's Weekly Skin Alteration assessment dated [DATE] revealed, Coccyx (Description) red .Groin (Description) red. During an observation and interview on 03/13/2020 at 1:02 P.M., Resident #111's buttocks had two nonblanchable quarter size areas on the left buttock and the right buttock approximately 4 inches down from the top of the intergluteal cleft. Resident #111 yelled out loudly in pain when the area was cleaned off by the CNA's (CNA R and CNA Z). Resident #111 reported that she does choose to stay in her seat all day and recognized that it increased her chances of having skin break down. During an interview on 03/13/2020 at 2:50 P.M., Medical Records (MR) K reported that there were no other skin assessments to be scanned into the EHR for Resident #111, 112, 123, or #124. MR K stated, the ones (skin assessments) in the computer (EHR) are the most up to date available. Review of the facility Pressure Ulcers form located in the Infection Prevention/Surveillance binder revealed no entries for the month of March 2020. Review of the (Name Omitted) Specialists form (also known as the Physician Communication Form) revealed no entries from the 100 Unit or the 200 Unit regarding pressure ulcers/skin breakdown. During an interview on 03/13/2020 at 2:50 P.M., Physician XX reported that he was unaware of any new or preexisting pressure ulcers in the facility. Physician 'XX reported he would expect to be notified of a pressure ulcer via the Physician Communication Form. Physician XX reported that he would expect the nursing staff to documenting any irregularities regarding pressure ulcers or any skin breakdown in the Electronic Health Record (EHR). During an interview on 03/04/2020 at 3:04 P.M., LPN OO reported that she had concerns with resident care being completed well or completed at all because of

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 7) lack of staff available to assist residents with turns and safe transfers. During an interview on 03/05/2020 at 9:08 A.M., CNA V reported that there were not enough staff to meet the needs of the residents. CNA V stated, residents are being left in bed on second shift for dinner because there are not enough staff to get them back to bed after dinner. CNA V reported that staffing on 2nd shift is so short that residents will go to bed before dinner in their gowns and do not get back up because there were not 2 staff available to assist. CNA V reported that residents are not being turned every 2 hours because it is impossible without enough staff members. During an interview on 03/05/2020 at 12:11 P.M., CNA GG reported resident have to wait because there were not enough staff to do 2 person assists. CNA GG reported it would be harder to assist residents after dinner because of the large amount of residents wanting to get back to bed. CNA GG reported it was difficult to assist residents with repositioning every 2 hours because of the amount of responsibilities that would need to be completed with little staff. During an interview on 03/06/2020 at 10:21 A.M., CNA AA reported that the facility is short staffed. CNA AA reported that because of low staffing residents are waiting extended periods of time to have their needs met and residents are not being repositioned every 2 hours as ordered. During an interview on 03/13/2020 at 2:00 P.M. CNA Z and CNA R reported that they cannot reposition the residents every 2 hours as ordered because there are not enough staff working on the units.
F 0725 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #:MI 234, MI 256, MI 285, and MI 637 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to meet resident needs for all residents residing in the facility, resulting in unmet care needs and the potential for impaired physical, mental, and psychosocial well-being. Findings include: Review of the Facility Assessment, date of assessment December 17, 2019, date assessment reviewed with QAA committee (Quality Assurance) January 24, 2019 revealed, Staffing plan 3.2. Based on the resident population and their identified needs for care and support, we have determined the following approach to staffing to ensure that facility has sufficient staff to meet the needs of the residents at any given time. Licensed Nurses (Direct Care Staff) 4-6 FTE/8 hour shifts .Certified Nursing Assistants 16-19 FTE/ 7.5 hour shifts. (The Facility Assessment had not been updated with current Administrator and Director of Nursing.) Resident #110 Review of a Face Sheet revealed Resident #110 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 1/20/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #110 was cognitively intact. Review of the Functional Status revealed that Resident #110 required extensive 1 person assist for bed mobility, dressing, toileting, and personal hygiene and extensive 2 person assistance for transferring. Review of Section M Skin Conditions revealed Resident #110 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an interview on 03/04/2020 at 3:36 P.M., LPN LL reported that Resident #110 has a pressure ulcer on his back and his buttocks. During an observation on 03/12/2020 at 8:57 A.M., Resident #110 had a form of barrier bandage on the left side of his buttocks. The skin surrounding the bandage on his right buttocks was deep purple/red and it was non blanchable. The bandage was dated 3/11 with no time written on the bandage. During an observation on 03/13/2020 at 12:16 P.M., Resident #110's bandage was removed by LPN JJ. Resident #110's bilateral buttocks was a deep purple/red and it was non blanchable. Resident #112 Review of a Face Sheet revealed Resident #112 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #112, with a reference date of 2/20/20 revealed a Staff Assessment of Mental Status score of 3 which indicated Resident #112 was severely cognitively impaired. Review of the Functional Status revealed that Resident #112 required extensive 1 person assistance for bed mobility and toileting, total dependence of 2 persons for transferring, and total dependence of 1 person for dressing, eating, and personal hygiene. Review of Section M Skin Conditions revealed Resident #112 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an observation on 3/13/2020 at 1:30 P.M. Resident # 112's left gluteal fold had a small open area approximately 3 cm round. Resident #123 Review of a Face Sheet revealed Resident #123 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #123, with a reference date of 2/10/20 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated Resident #123 was severely cognitively impaired. Review of the Functional Status revealed that Resident #123 required extensive 1 person assist for bed mobility, dressing, toileting, and personal hygiene and extensive 2 person assistance with transferring. Review of Section M Skin Conditions revealed Resident #123 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an observation on 03/13/2020 at 1:45 P.M. Resident #123's right gluteal fold had an open area approximately 3cm length x 1cm width. Resident #123's left gluteal fold had a small open area less than 1cm x 1cm. When the CNA was performing perineal care Resident #123 loudly exclaimed Ouch! [MEDICAL CONDITION] fire. Resident #124 Review of a Face Sheet revealed Resident #124 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 1/6/20 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #124 was cognitively impaired. Review of the Functional Status revealed that Resident #124 required extensive 1 person assistance with bed mobility, dressing, toileting, and personal hygiene and total dependence of 2 persons for transferring. Review of Section M Skin Conditions revealed Resident #124 was at risk for developing pressure ulcers/injuries and did have a pressure injury at the time of the assessment. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 10/8/19, Section M Skin Conditions revealed, Resident #124 was at risk for developing pressure ulcers/injuries and did not have a pressure injury at the time of the assessment. During an observation on 3/13/20 at 2:00 P.M. the entirety of Resident #124's buttocks was a deep purple/red color and was non blanchable. On the right gluteal fold there was a large open bleeding area approximately 1cm x 3 cm. During an interview on 03/03/2020 at 8:55 A.M., Certified Nursing Assistant (CNA) DD reported that the facility is consistently short staffed. CNA DD reported that many staff have been working double shifts due to mandation. CNA DD reported that on Sunday (3/1/20) there were not enough staff to care for the residents due to call offs and staff members quitting. During an interview on 03/03/2020 at 9:24 A.M., CNA BB reported that 2nd shift is frequently short staffed. CNA BB reported that frequently on 2nd shift the residents that require 2 person assist are put to bed at approximately 3:00 P.M. before it gets busy with the dinner rush and putting residents to bed for the night. CNA BB reported it is difficult to find staff to get residents that require 2 person assist into bed so they will go to bed at 3PM until the next morning. CNA BB reported there are not enough staff to hoyer or sit to stand residents (equipment used to assist residents with mobility that requires 2 people). CNA BB stated, If they aren't gowned and in bed who will get them to bed? They have to eat dinner in their room and can't go to activities because 1 aide can't take care of 20 something people. During an interview on 03/03/2020 Licensed Practical Nurse (LPN) MM reported that because the facility is short staffed, resident care is lacking. LPN MM reported that staff cannot spend the time they should with residents. LPN MM reported that the amount of falls has increased and family members are taking their loved ones out of the building because the residents are not receiving the care they require. During an interview on 03/04/2020 at 11:51 A.M., CNA CC reported that because the facility is short staffed residents wait a considerable amount of time for assistance because there are so many 2 assist residents. CNA CC reported that unfortunately they do have to wait until staff are able to find additional staff members. During an interview on 03/04/2020 at 3:04 P.M., LPN OO reported that the amount of residents the nurses are responsible for when there is a call in is unsafe. LPN OO reported that working more than 16 hours causes her to feel that she cannot safely pass medications. LPN OO reported that she had concerns with resident care being completed well or completed at all because of lack of staff available to assist residents with turns and safe transfers. During an interview on 03/04/2020 at 3:36 P.M., LPN LL stated, Staffing is an issue today. 2 CNA's will be late and 1 called in. LPN LL reported that this (call ins) are happening more frequently. During an interview on 03/04/2020 at 4:23 P.M., Confidential Resident (CR) JJJ reported that there are not enough staff working to ensure that all residents get showers on their shower day. CR JJJ reported that he did not receive his shower yesterday (3/3/20) because there was one 1 CNA and 1 nurse working on his unit. CR JJJ reported that they need more staff working and a couple more people to help out with showers. During an interview on 03/05/2020 at 9:08 A.M., CNA V reported that there were not enough staff to meet the needs of the residents.

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F 0725 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 8) CNA V stated, residents are being left in bed on second shift for dinner because there are not enough staff to get them back to bed after dinner. CNA V reported that staffing on 2nd shift is so short that residents will go to bed before dinner in their gowns and do not get back up because there were not 2 staff available to assist. CNA V reported that residents are not being turned every 2 hours because it is impossible without enough staff members. During an interview on 03/05/2020 at 12:11 P.M., CNA GG reported resident have to wait because there were not enough staff to do 2 person assists. CNA GG reported it would be harder to assist residents after dinner because of the large amount of residents wanting to get back to bed. CNA GG reported it was difficult to assist residents with repositioning every 2 hours because of the amount of responsibilities that would need to be completed with little staff. During an interview on 03/05/2020 at 12:30 P.M., HR G reported that the DON had been working both the as a direct care nurse and as the DON. HR G reported that they have had an increased number of call ins and turnover and the residents must have a nurse to care for them. During an interview on 03/05/2020 at 3:21 P.M., LPN PP, CNA EE, and CNA LLL reported that the facility was working with unsafe staffing ratios. During a Confidential Group Meeting on 3/04/2020 at 1:00 P.M. 9 residents were present. 6 out of 9 residents reported that the facility was short staffed. Confidential Resident (CR) BBB reported that she had to wait an extensive amount of time for her call light to be answered. CR BBB reported that she had been incontinent of urine because of the amount of time she waited and I started crying. CR EEE reported that at times he has waited up to an hour to have her call light answered. CR DDD reported that she has a condition that causes her to be incontinent of urine. CR DDD reported that she has waited up to 3 hours to have her brief changed. CR CCC reported that she has attempted to transfer herself because of the amount of time it takes to have staff assist which resulted in a fall. CR CCC reported there are not enough staff to assist with showers because our shower girl is pulled to the floor so then we do not get a shower.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** This citation pertains to intake #: MI 234 Based on interview and record review, the facility failed to maintain and designate a Registered Nurse (RN) to serve as the Director of Nursing (DON) on a full-time basis, resulting in the potential for inadequate coordination of resident care with negative clinical outcomes affecting all residents residing in the facility. Findings include: Review of the Daily Schedule revealed that on 2/28/20 and 3/10/20 there was no Registered Nurse (RN) to work in a 24 hour period. During an interview on 03/13/2020 at 11:50 A.M., Human Resources G reported that there was no RN working on 2/28/20 or 3/10/20. HR G reported that an RN should work 8 hours in a 24 hour period. Review of Director of Nursing (DON) B's Time Clock Missed Punch Request Form dated 3/1/20 revealed, Punch IN 1:00 A.M .Punch OUT 6:45 AM .Consider this your 8 RN hours (total of 5 hours and 45 minutes). Review of DON B's schedule revealed that DON B hours worked on 3/1/20 from 1:00 A.M. until 6:45 A.M. as a direct care nurse. On 3/2/20 DON B worked from 8:30 A.M.5:00 P.M. in the DON capacity and then from 10:30 P.M.-3:00 A.M. as a direct care nurse. DON B worked 3/3/20 from 9:00 A.M.-1:30 P.M. in the DON capacity. On 3/4/20 DON B from 5:45 A.M.-12:15 P.M. in the DON capacity. On 3/6/20 DON B worked from 10:15 P.M. until 11:15 A.M. (3/7/20) as a direct care nurse. These days and hours were verified with HR G. The amount of DON hours worked for the week of 3/1/20 to 3/7/20 was 19.5 hours. During an interview on 03/05/2020 at 12:30 P.M., HR G reported that the DON had been working both the as a direct care nurse and as the DON. HR G reported that they have had an increased number of call ins and turnover and the residents must have a nurse to care for them.
F 0729 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.** This citation pertains to intake # MI 234 Based on interview and record review, the facility failed to ensure staff were certified prior to providing care, resulting in the potential for improper care and services and unmet care needs for all facility residents. Findings include: Review of Certified Nursing Assistant (CNA) U's employee file revealed she was hired on 7/31/19. There was no documentation of CNA U's CNA education or a copy of her certificate. Review of the State of Michigan Nurse Aide Registry revealed no certification on file. Review of the Daily Schedule revealed that CNA U worked on 2/21/20, 2/22/20, 2/28/20, 3/2/20, 3/6/20, and 3/7/20. Review of CNA W's employee file revealed she was hired on 4/4/19. There was no documentation of a valid Michigan Certified Nursing Assistant certification. A copy of CNA W's Florida CNA certification was received. Review of the State of Michigan Nurse Aide registry revealed no certification on file. Review of the Daily Schedule revealed that CNA W worked as a CNA on 2/24/20, 2/25/20, 3/3/20, and 3/5/20. Review of CNA X's employee file revealed she was hired on 10/23/19. CNA X's CNA class was completed on 11/10/19 and her State Certification Exam was scheduled for 3/24/20. During an interview on 03/12/2020 at 3:21 P.M., Human Resources (HR) G reported that CNA U, CNA X, and CNA W were removed from the patient care duties as of 3/12/20.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Post nurse staffing information every day.** This citation pertains to intakes #:MI 234, MI 256, MI 285, and MI 637 Based on observation, interview, and record review, the facility failed to visibly display nurse staffing information in a prominent place that was readily accessible to residents and visitors and ensure the posted information was current, resulting in a lack of available and/or current staffing information to visitors and residents. Findings include: During an observation on 3/3/20, 3/4/20, 3/5/20, and 3/6/20 no nurse staffing information was posted in the facility. During an observation on 3/11/20 and 3/12/20 the posted nurse staffing information was dated 3/10/20 and had incorrect information. Review of the POS [REDACTED]. During an interview on 03/12/2020 at 12:34 P.M., Human Resources (HR) G reported that the staff member that was in charge of the daily nurse staffing information had quit and no facility staff member had been designated to complete the task. HR G reported that the last daily nurse staffing information completed was on 2/20/20 and 3/10/20. HR G reported that Scheduler NNN was designated to complete the posted nurse staffing information as of 3/12/20.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 234 Based on observation, interview, and record review, the facility failed to identify, prevent and track respiratory illness in residents and staff to prevent the spread of respiratory illness in the facility for 9 residents (Resident #103, #109, #111, #113, #114, #115, #116, #118, and #119) and 2 staff becoming ill with an upper respiratory illness beginning 3/5/20 resulting in an immediate jeopardy when, beginning on 3/5/20, facility staff did not perform surveillance, implement established infection control standard interventions to provide care for, and prevent the spread of an upper respiratory infection to staff members and residents in the facility. This deficient practice placed all residents at risk for serious harm and/or death. On 3/6/20 the Administrator was verbally notified and received written notification of the immediate jeopardy that was identified on 3/5/20 due to the facility's failure to implement an infection control program and designate an infection control nurse to oversee the program. A written plan for removal for the immediate jeopardy was received on 3/11/20 and the following was verified on 3/11/20: 3/6/2020 Element #1 - what has been done for the residents identified/listed in the IJ notice? What IC protocols were put in place for these residents? 3/06/2019 at 2:00 pm, in response to the state surveyor's concerns, 53 additional residents were assessed by the charge nurse for cold and flu symptoms. 11 residents were found to have exhibited symptoms. 03/06/2019 at 1:30 pm (name omitted), a certified infection control nurse, 3/6/2020 was immediately appointed facility infection control nurse. She was immediately informed of the situation and consulted for further plan of action. 03/06/2019 at 3:05, (physician name omitted) was directed to evaluate residents who presented with symptoms. Three additional residents were added for his review. Following is a list of residents and the course of action as determined by the (sic) (physician name omitted). 109 (initials omitted) - 3/6/2020 Resident showing cold/flu symptoms - examined and cleared by physician. Resident is in a Private room, Flu like symptoms started Res. Flu swabbed 3/11/2020 At 3pm. Waiting for results. Standard Droplet Precautions have been put in place. PPE (personal protective equipment) station deployed, signs put outside of room. Results returned 3/11/2020 Result from Swab Negitive (sic) for Flu. 121 (initials omitted) 3/11/2020 3pm Resident showing respiratory symptoms, physician ordered A Flu swab awaiting results standard Droplet precautions have been put in place 3/11/2020. PPE station deployed, signs posted outside of room. 3/11/2020 Result from Swab Negitive (sic) for Flu. 118

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	235573	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACEWAY AT COUNTRYSIDE	120 BASELINE RD SOUTH HAVEN, MI 49090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 9) (initials omitted) resident showing Cold/Flu symptoms, examined by physician Flu Swab order 3/7/2020. Result positive for influenza A. Resident placed in Private Room. Droplet Precautions implemented, PPE station deployed, signs posted outside of room. Resident meals taken in room. Physician order for [REDACTED]. 03/07/2020 6:00 am result positive for influenza A. Resident placed in Private Room. Droplet precautions implemented, PPE station deployed, signs posted outside of room. Resident meals taken in room. 03/07/2020 Physician order [MEDICATION NAME] 75mg X 7 days, drop shipped by pharmacy given on 03/8/2020 during morning med pass. 120 (initials omitted) Flu like symptoms, swab culture ordered3/11/2020 at 3PM Resident placed in Private Room. Standard Droplet Precautions implemented, PPE station deployed, signs posted outside of room. Resident meals taken in room. 3/11/2020 Results from swab, Negative for flu. 103 (initials omitted) resident showing Cold/Flu symptoms, examined by physician culture swab order. On 03/07/2020 6:00 am Result positive for influenza A. Resident placed in Private Room. Standard Droplet Precautions implemented, PPE station deployed, signs posted outside of room. Resident meals taken in room. [MEDICATION NAME] 75mg X 7 days, drop shipped by pharmacy given on 03/8/2020 during morning med pass. 107 (initials omitted) Resident showing Flu like signs and symptoms on3/11/2020. Flu swab ordered 3pm 3/11/2020 awaiting results. Resident will be placed in a private room. Standard Droplet Precautions put in place PPE put in place signs outside door. 3/11/2020 Results from Swab, Negative for Flu. 111 (initials omitted) resident showing Cold/Flu symptoms. Examined by physician ordered Flu swab and CXR order. Results negative. 3/6/2020 . 113 (initials omitted) resident showing cold/flu symptoms. Examined by physician. Flu Swab ordered 3/8/2020 Neg. (negative) Res. (resident) Is in a Pri. (private) Room. 114 (initials omitted) resident showing Cold/Flu symptoms. Examined by physician culture swab and CXR order. Results negative. 3/6/2020 115 (initials omitted) resident showing cold/flu symptoms. Examined by physician Flu swab ordered 3/09/2020 positive results 3/11/2020.Standard Droplet Precautions put in place on 3/11/2020, In private room. PPE put in place signs are outside of room. 3/11/2020 Results from Swab, Negative for Flu. 116 (initials omitted) resident showing cold/flu symptoms. Examined by physician. On 3/6/2020. Resident cleared, no treatment ordered. Cough syrup ordered for cough. 3/11/2020 Flu swab ordered D/T (due to) signs and flu like symptoms. Flu swab ordered 3/11/2020. In Private room. Standard Droplet Precautions began on 3/11/20 PPE put in place signs hung outside of room. 3/11/2020 Results from Swab, Negative for Flu. Outer doors to unit were closed on 3/6/2020 3PM and visitors were screened at nurses desk and informed of the presence of flu before being allowed to enter. Signs were posted at every affected resident's door to request visitors to see the nurse before entering. Element #2 - what has been done for other residents at risk and how have they been reviewed. What was the outcomes? 03/06/2020 - 2:50 to 3:05 pm - All residents were assessed by charge nurse for cold/flu like symptoms. All residents who exhibited symptoms were referred to physician for evaluation. Resident's results listed in Element #1. 03/06/2020 - Beginning afternoon shift, all residents will be assessed for cold/flu symptoms every shift for 7 days ending 3/15/2020. 03/06/2020 - 5:00 pm - County Public Health Department was connected (sic) and were closed. Contact made on 03/09/2020 - See below 03/06/2020 all staff were informed of the presence of cold/flu symptoms and in-serviced on infection control policy/procedure, identifying and reporting cold/flu symptoms, hand washing, and PPE usage and disposal. In-service related to current situation began for all staff at 7pm afternoon shift and 9:45pm midnight shift and will continue prior to every shift for all staff until all have been in-serviced. PRN staff have been contacted via phone and will receive in-service prior to starting their next shift. To date 3/10/2020 2:30pm - 85% of 79 staff have been in-serviced. Remaining 12 will also be in-serviced prior to their next shift. 03/07/2020 - After we received positive results, signs were placed at the public entrance serving notice of the presence of cold/flu and discouraging those visitors exhibiting symptoms form entering. Signs were also placed outside affected residents' rooms requesting visitors to see nurse before entering. 03/07/2020 - Employee call in sheets kept at the each nurses station near the phone and given to each department head. When taking a Call-in staff must be prompt caller to report flu-like symptoms, staff In-serviced to that effect. Call -in for illness are given to the IC (infection control) Nurse for tracking. (sic) As of 3/7/20 Staff who show up to work presenting with Col/flu (sic) like symptoms will be sent home. If illness is flu related, staff must be symptom free before returning to work. Charge nurse to review call-ins after hours and will forward to IC nurse for review in case of reported flu symptoms. Staff before entering unit will have their temp taken to assure there are no Flu like symptoms. 03/08/2020 - As a proactive measure and at the urging of the Infection Control nurse, [MEDICATION NAME] was given to all remaining residents. 03/09/2020 - 10:05 am Infection Control Coordinator (name omitted) spoke with (name omitted) at the local Health Dept. Report was given as stated above. Reported signage is posted at the front entrance. (name omitted) felt we were in line with the CDC guidelines and to report when there are any changes. 3/6/2020 Infection Control In-service related to current situation began for all staff at 7pm afternoon shift and 9:45pm midnight shift. Will continue at the beginning of the shift every shift (sic) until all staff have received in-service. In-service-staff will communicate to the nurse, signs and symptoms indicating resident may possibly have an infection. The nurse will conduct an assessment. The nurse will notify the Physician of the assessment findings and follow any orders and recommendations given. The nurse will document suspicion/evidence of infection in the resident medical record that notification to the Physician and family and if any orders were received. The infection Control Coordinator will be notified of the change of condition by using the 24 hour report or direct notification. Element #3 - What systematic items have occurred to remove the IJ (all other items you've done/going to do). 3/7/2020 Under the design and direction of IC Nurse and based on CDC guidelines the following protocol has been established. After a case of laboratory confirmed Influenza, and any suspected cases of influenza, As of 3/6/20, affected residents will be placed in a private room under Droplet Precaution Isolation. In the event no private room is available, residents will be (cohorting) under droplet precaution isolation. On 3/6/20 Please See Nurse Before Entering sign will be place outside resident door. As of 3/7/20 PPE Station set-up outside resident door with picture instruction who had Positive Flu results (sic) Beginning 3/7/20 staff were informed of positive influenza results and instructed on the use of PPE and hand washing. 3/7/2020, individual families will be notified of resident change of condition. If flu becomes widespread. Notification signs will be posted throughout facility. Beginning 3/9/20 Will report laboratory confirmed cases of influenza to 5the (sic) local health department. 3/11/20 starting Regular handwashing and universal precautions education given to staff. Beginning 3/12/2020 New hires will receive handwashing in-service during orientation. Although the immediate jeopardy was removed on 3/11/20, the facility remained out of compliance at a scope of widespread and severity of no actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency. Findings include: Review of the facility policy Monitoring Infection Control Practices last revised 12/2015 revealed, The facility's Infection Control Coordinator/Preventionist will conduct routine monitoring and surveillance to determine compliance with infection control policies and practices. Procedures: Resident Surveillance-If suspicion or evident (sic) of an infection is detected within the resident population the following should be done: 1. Staff will communicate signs and symptoms indicating a resident infection to the nurse, this may include usage of the Stop and Watch (electronic health record tool). 2. The nurse will conduct an assessment: the McGreer's criteria will be utilized to assist in determination of infection. 3. The nurse will notify the physician of assessment findings and follow any orders and recommendations given. 4. The nurse will report the suspicion/evidence of infection to the Director of Nursing and family. This should be done verbally and through the use of the 24 hour Nursing Report. Additional directives may be given to the nurse by the Director of Nursing if suspicion/evidence presents if (sic) risk of transmission to other resident or employees. 5. The nurse will document the suspicion/evidence of infection in the resident medical record that notification to the physician and family and if physician orders were received. Utilization of McGreer's Criteria and SBAR (Situation, Background, Assessment and Recommendation) may be part of the documentation/assessment provided in the resident's medical record. 6. As further information is collected the nurse will document in the resident record. 7. The facility's Infection Control Coordinator/Preventionist will collect data. 8. The Infection Control Coordinator/Preventionist shall review and analyze data monthly (or more frequently if warranted) for trends, rates of infections, clusters or infections, causes of infections and to evaluate the effectiveness of the facility's infection control program. 9. The Coordinator/Preventionist will complete the Monthly Infection Control Reports present report findings and analysis to Quality Assurance and Performance Improvement Committee, and review the effectiveness. Employee Surveillance: 1. Staff are responsible for reporting illness, including signs and symptoms to the facility. 2. An absence Report will be completed if the employee is deemed unable to work. Employees with the following illnesses are not allowed to work until deemed non-contagious .Pneumonia .Flu .Fever .4. The data from the employee's illness will be collected and logged into the facility's electronic data system which will provide a comprehensive log and monthly report. The facility Infection Control Coordinator/Preventionist will monitor logs weekly, monthly (or more frequently if warranted). A facility floor plan will be created of infection occurrences that coordinate with logs to clarify and to assess for trends, rates of infections, and clusters of infections. 5. The Infection Control

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) Coordinator/Preventionist will utilize logs, reports to assist in potential causes of infections and to evaluate the effectiveness of the facility infection Control Program. Facility Surveillance: 1. Surveillance of the workplace to ensure that established infection control practices are observed and protective clothing and equipment are available and properly used. 2. Coordinator/Preventionist will participate in investigations of known or suspected exposures to blood/body fluids to establish the conditions surrounding the exposure event. 3. Data will be gathered, reviewed, and events investigated, if needed of known or suspected transmission of Nosocomial infections (facility acquired infections). 4. Identify opportunities for training to prevent the recurrence of occupational exposure, nosocomial infections by improving work practices, or use of protective equipment. 5. Observations to determine effective implementation of hand hygiene and use of disposable gloves by all departments to prevent spread of infection. 6. Identification of noncompliance with established infection control practices and to report findings to the Administrator and to appropriate department leaders. 7. A summary report of such instances will also be provided to the QAPI Committee along with corrective actions taken. 8. The Infection Coordinator/Preventionist and/or the Infection Control Committee shall provide reports that summarize trends, causative factors of infections, effectiveness of current infection control measures and recommendations if necessary to improve practices to the QAPI Committee. During an interview on 03/04/2020 at 10:27 A.M., Director of Nursing (DON) B reported that the previous DON (DON PPP) quit without notice and did not designate tasks and did not give DON B any orientation on what was expected of her. DON B reported that she was not doing infection control surveillance/monitoring for the facility. During an interview on 03/04/2020 at 10:33 A.M., Licensed Practical Nurse (LPN) JJ reported that prior to DON PPP, LPN JJ was responsible for infection control surveillance/monitoring. LPN JJ reported that no nursing staff were delegated to complete the infection control surveillance/monitoring after DON PPP abruptly quit. Review of the facility Resident Infection Control Log revealed the form had not been completed for the month of March 2020. The Resident Infection Control Log revealed: resident, room number, admitted , onset date, site, symptoms, culture date, x-ray date, organism, antibiotic, type of precautions, nosocomial (disease originating from hospital), hospitalized , re-culture date, date resolved, and/or preventative measures. Review of the facility map for infection control surveillance revealed the form had not been completed for the month of March 2020. During an interview on 03/03/2020 at 2:13 P.M., Licensed Practical Nurse (LPN) JJ reported that she was not aware of any residents that exhibited upper respiratory infections. During an interview on 03/06/2020 at 3:31 P.M., LPN JJ reported that all respiratory ailments should have been documented in a progress note and on the flow sheets, especially during flu season. Resident #103 Review of a Face Sheet revealed Resident #103 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #103's Progress Notes dated 3/7/20 revealed, productive cough. lung sounds in all four lobes. resident is alert and oriented, up in her chair. she is in the doctors book to be looked at first thing. this nurse will continue to monitor throughout this shift .his nurse called doctor (name omitted) for the cough and lung sounds. he ordered a flu swab and for the patient to stay in her room. waiting on the results .Nasal flu swab results returned positive for influenza A. Review of Resident #103's laboratory results dated [DATE] revealed, Influenza A Positive. Resident #109 Review of a Face Sheet revealed Resident #109 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/05/2020 at 10:01 A.M., Certified Nursing Assistant (CNA) Y stated, (Resident #109) is very sick today. Review of the facility Physician Communication Form on 3/6/20 revealed, (Resident #109) cough, congestion. There was no date written next to the entry. Review of Resident #109's Physician Order dated 3/4/20 revealed, [MEDICATION NAME] (cough suppressant) 100mg/ml 10ml PO (by mouth) q6' prn (every six hours as needed) for cough x 7 days. During an interview on 03/05/2020 at 9:45 A.M., LPN PP reported that Resident #109 sounds terrible today. When asked if Resident #109 had any abnormal vital signs LPN PP reported that Resident #109 had not had vital signs assessed since December 2019. Review of Resident #109's Progress Note dated 3/5/20 at 10:17 P.M. revealed, (Resident #109) complains of congestion. Vital signs taken and recorded, WNL (within normal limits). PRN medication given and effective. Review of Resident #109's Progress Note dated 3/7/20 revealed, Resident's voice hoarse when talking, no evidence of coughing. Respirations non-labored. Encouraged oral fluids. VS(vital signs): T(temperature) 99.4, P (pulse) 68, R (respirations) 12, BP (blood pressure) 93/48, SaO2 (oxygen level) 96%/RA (room air). Will continue to monitor Review of Resident #109's laboratory results revealed Resident #109 was not swabbed or placed in isolation until 3/11/20. During an interview on 03/11/2020 at 1:33 P.M., Physician X reported that he was ordering Resident #109 to be placed in isolation for her symptoms until the flu swab was resulted. Resident #111 Review of a Face Sheet revealed Resident #111 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/05/2020 at 10:01 A.M., Certified Nursing Assistant (CNA) Y stated, (Resident #111) was very sick last week. Review of the nurse to nurse report sheet Unit 1 East Resident List on 3/6/20 at 9:08 A.M. revealed, Resident #111 wheezing throughout. Review of Resident #111's laboratory results revealed Resident #111 was not swabbed until 3/6/20 at 7:30 P.M. Influenza result was negative. Review of Resident #111's Progress Note dated 3/6/20 at 11:00 P.M. revealed, C/O (complaints of) cough. Doctor in facility and ordered flu nasal swab and cxr (chest x-ray). PRN (as needed) cough syrup given. Lung sounds are clear with congestion noted in upper airways. No difficulty noted with breathing. Swab test completed and sent to lab. Waiting on x-ray to be taken. Resident #113 Review of a Face Sheet revealed Resident #113 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/04/2020 at 1:00 P.M., Activity Director J reported that Resident #113 would not be attending resident council because he was not feeling well. During an interview on 03/04/2020 at 4:23 P.M., Resident #113 reported that he has had a cold and cough for approximately 2 weeks. During an observation on 03/06/2020 at 9:46 A.M., Resident #113 was in his electric scooter, went from the 200 Unit (back of building) to the front entrance way with tissues hanging out of his nose. Resident #113 reported that he is still not feeling better. Review of the facility Physician Communication Form on 3/6/20 revealed, (Resident #113) cough, sore throat. There was no date written next to the entry. Review of Resident #113's Progress Note dated 3/6/20 at 6:02 P.M. revealed, resident was seen by doc for flu symptoms. Review of Resident #113's Progress Note dated 3/8/20 at 12:55 P.M. revealed, Resident continues on [MEDICATION NAME] (medication used to lessen symptoms of the [MEDICAL CONDITION]) with no adverse reactions noted. Was swabbed for the flu, negative, he does have a loose productive cough, lung sounds clear. Review of Resident #113's laboratory results revealed Resident #113 was not swabbed until 3/8/20 at 8:03 A.M. Influenza result was negative. Resident #114 Review of a Face Sheet revealed Resident #114 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/05/2020 at 9:45 A.M., LPN PP reported that Resident #114 is congested. Review of Resident #114's laboratory results revealed Resident #114 was not swabbed until 3/6/20 at 7:30 PM. Influenza result was negative. Review or Resident #114's Progress Note dated 3/6/20 at 10:53 P.M. revealed, Nasal drainage noted. Doctor in facility and gave order for flu nasal swab and cxr. Swab completed and sent to lab. CXR ordered and waiting for x-ray completion. No coughing noted. No difficulty breathing. Resident #115 Review of a Face Sheet revealed Resident #115 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/05/2020 at 9:51 A.M., Resident #115 reported that she is not feeling well and has a runny nose and a sore throat. Review of the facility Physician Communication Form on 3/6/20 revealed, (Resident #115) cough, congestion. There was no date written next to the entry. Review of Resident #115's Physician Order dated 3/4/20 revealed, [MEDICATION NAME] (cough suppressant) 100mg/ml 10ml PO (by mouth) q6' prn (every six hours as needed) for cough x 7 days. During an interview on 03/05/2020 at 9:45 A.M., LPN PP reported that Resident #115 had an order for [REDACTED].#115's Progress Note dated 3/5/20 at 10:18 P.M. revealed, Complains of Feeling under the weather. Vital signs taken, WNL (sic) Review of Resident #115's laboratory results revealed Resident #115 was swabbed on 3/9/20 at 3:30 P.M. and the results were reported on 3/9/20 at 4:50 P.M. The results were positive for Influenza A. During an observation on 03/11/2020 at 10:31 A.M., Resident #115 was in her room and not in isolation. During an interview on 03/11/2020 at 10:40 A.M., LPN RRR was asked why Resident #115 was not placed in isolation when she A.) swabbed for influenza and B.) when the result came back positive and she stated, I don't know. Resident #116 Review of a Face Sheet revealed Resident #116 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 03/06/2020 at 11:44 A.M., Resident #116 reported, I have a cold today. Review of Resident #116's laboratory results revealed Resident #116 was not swabbed until 3/11/20 at 3:00 P.M. Influenza result was negative. Review of Resident #116's Progress Notes revealed no assessment for upper respiratory symptoms on 3/6/20, 3/7/20, 3/8/20, 3/9/20, 3/10/20, or 3/11/20. Progress Note dated 3/11/20 revealed, Nasal swab for influenza obtained and sent to lab, results are negative for Influenza A &B. Resident #118 Review of a Face Sheet revealed Resident #118 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #118's Progress Note dated 3/6/20 at 5:58 P.M. revealed, resident had a cough that doc looked at and ordered a chest x-ray

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 11) along with [MEDICATION NAME] (sic) PRN (cough medication as needed). Review of Resident #118's Progress Note revealed, Late Entry-Created Date 3/8/20 12:38 P.M. Effective Date: 3/7/20 at 12:36 P.M. Chest x-ray and flu swab obtained, resident is positive for influenza A . Review of Resident #118's laboratory results revealed Resident #118 was not swabbed until 3/7/20 and the results were reported on 3/7/20 at 12:16 P.M. Resident #118 was positive for Influenza A. Resident #119 Review of a Face Sheet revealed Resident #119 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #119's Progress Note dated 3/6/20 revealed, resident has a cough. doc ordered a chest x-ray along with a flu swab and [MEDICATION NAME] (sic) PRN Review of Resident #119's physician progress notes [REDACTED].#119) was recently diagnosed with [REDACTED].#119's laboratory results revealed no lab results for the Influenza A swab. Review of the facility Employee Infection Control Log revealed the form had not been completed for the month of March 2020. This form tracks: employee, (job) position, date of onset, signs/symptoms reported, and date of resolution. Review of the employee call in forms revealed employee call ins were not tracked since January 2020 During an interview on 03/05/2020 at 11:39 A.M., Activity Assistant II reported that there was a respiratory bug going around with the employees. During an interview on 03/06/2020 at 8:28 A.M., Laundry Staff UU reported that she called into work on 03/06/2020 because of a sore throat and stuffy head. During an interview on 03/06/2020 at 10:21 A.M., CNA AA reported that she called into work on 03/06/2020 because of sneezing, runny nose, and feeling generally unwell. During an interview on 03/06/2020 on 12:30 P.M., Physician XX reported that he was unaware of the symptoms of upper respiratory infections going around the facility. Physician XX was asked if he was aware of Resident #111, #113, #114, and #116 complaining of upper respiratory infections. Physician XX reported he was notified of Resident #109 and Resident #115 which was why he ordered cough medication. Physician XX reported that he would have looked into other residents had he known they had symptoms because of it being flu season and the dangers of elderly becoming ill. Physician XX reported that he did not see any documentation in progress notes or the Physician Communication Form of residents with upper respiratory infection symptoms. During an interview on 03/11/2020 at 1:33 P.M., Physician XX reported that when a flu swab is ordered on a resident the resident should be put into isolation precautions until the swab is resulted.