STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235504	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE OASIS AT ADRIAN REHABILITATION AND NURSING CTR	130 SAND CREEK HWY ADRIAN, MI 49221

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 382. Based on interview and record review, the facility failed to notify the physician of an acute change in condition in 1 resident (#4) of 2 residents reviewed for change in condition, resulting in Resident #4's physician not being notified in a timely manner, and Resident #4 being admitted to the hospital in Septic Shock (serious condition that occurs when a body-wide infection leads to dangerously low blood pressure). Findings Include: Review of the medical record and Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was an [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment revealed that Resident #4 had unclear speech, was usually understood, usually understands, was severely impaired cognitively and required staff assistance with activities of daily living (ADLs). Review of the hospital record revealed that Resident #4 was admitted to the hospital on [DATE], Due to the patient having 2/4 sirs (An [MEDICAL CONDITION] state affecting the whole body) positive urinalysis for a UTI, acute kidney injury and lactic acidosis (lactic acid build up in the bloodstream. Lactic acid is produced when oxygen levels, become low in cells within the areas of the body where metabolism takes place) the patient was admitted for [MEDICAL CONDITION] due to UTI (urinary tract infection) and acute metabolic [MEDICAL CONDITION] (brain malfunction) with [MEDICAL CONDITION] (high blood sodium levels) due to severe dehydration. Review of Dr. J's progress note dated 1/27/20 (Monday) revealed, Staff reports (Licensed Practical Nurse (LPN) I) resident with increased confusion, lethargy, restlessness, low BP (blood pressure), not eating or drinking well at all .Significant changes in mental conditions over the weekend .Over the weekend the nurse reported (Resident #4) is increasing lethargic, confused, restless, with increased agitation .It seems no one called the weekend on call doctor to report this information .Plan - nurse called for stat labs. Will start on IV (intravenous) fluids right now . During a telephone interview on 3/12/20 at 2:45 p.m., when asked about Resident #4's change in condition over the weekend (1/24/20-1/27/20) Dr J stated that he had seen Resident #4 before the weekend. Dr. J stated that on 1/27/20, the nurse had stated to him that over the weekend it was reported that Resident #4 was more lethargic, more confused and more restless. Dr J stated that he wanted stat labs and start IV because if the labs were worse, I would have sent him out of there (to the hospital). Dr. J continued, There was a change in his condition over the weekend and as far as I know nursing did not reach out to the on-call (physician) about the change. I went in on the 27th and I ordered the labs (LPN I) told me about the change over the weekend. Dr. J continued, I asked (LPN I) and she was told that he was more confused, lethargic and restless over the weekend and to me that was very concerning. I saw him first (on 1/27/20) and he looked more lethargic, I said that we need to get labs .I thought this was urosepsis and so when people are unstable for any reason, I do not want to wait. Dr. J stated that Resident #4 was sent to the hospital before the lab results were available. During this same interview, this surveyor reviewed the laboratory results with Dr. J, and discussed the change in the lab values from 1/24/20 to 1/27/20 which revealed Sodium increased from 158 to 166 (normal 136-145 mEq/L (milliequivalents per liter), white blood cell (WBC) count from 8.8 to 20.19 (normal 4.00-10.60 (10^3 units per microliter), BUN/Creat (lab results that indicate failing kidney function) increased from 69/2.16 to 76/3.04 (normal is 7-25/0.6-1.30mg/dL, milligram per deciliter). Dr. J stated that he was 100 percent sure and honest that there was a big change in condition over the weekend. When asked about the large increase in Sodium, BUN, Creatinine and WBCs, Dr. J stated if, I got the lab and his white count was 20,000 and his kidney functioning was worse and sodium was higher I would not keep him for a minute, I would not wait for anything. When asked if he should have been notified about this change in condition sooner, Dr. J stated, Yes, over the weekend something changed. Dr. J continued to talk about the current lab results and stated, So this meets the criteria of SIRS and I would have sent him right to the hospital .In this situation, this guy would go to ICU/CCU and loaded with ABX because he meets the criteria, and time is money (time is a valuable resource, therefore it is better to do things as quickly as possible). Dr. J continued, That jump from 8.8 to 20 (White Blood Cell Count), it doesn't happen out of nowhere, there was a big change of condition and it should have reported, it would have showed up Saturday or Sunday, should not have waited until Monday. During an interview on 3/12/20 at 11:57 a.m., when asked about Resident #4's change in condition over the weekend (1/24/20-1/27/20) LPN I was not able to recall that weekend.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 382. Based on interview and record review the facility failed to accurately assess, and document a resident's skin integrity, and update interventions to prevent the developing and worsening of pressure ulcers for 1 (Resident #4) of 1 resident reviewed for pressure wounds resulting in the developing and worsening of pressure ulcers that were not assessed by the wound nurse. Findings Include: Review of the medical record and Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was an [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS assessment revealed that Resident #4 had unclear speech, was usually understood, usually understands, was severely impaired cognitively and required staff assistance with activities of daily living (ADLs). Review of the hospital record dated 1/27/20 revealed, Decubitus ulcer of heel, bilateral established and worsening .bilateral feet with sores right heel approx size of 1/2 dollar and necrotic looking left heel with a small amount of purulent drainage noted . Review of the hospital's X-ray result dated 1/27/20 revealed, REASON FOR EXAM: Decubitus ulcer left foot possible osteo[DIAGNOSES REDACTED]. Ulcers on each heel .Right foot: There is soft tissue swelling about the foot. There is a small ulceration defects seen along the posterior aspect of the heel .Left foot: There is irregularity .along the posterior aspect of the calcaneus (heel bone). This could relate to early osteo[DIAGNOSES REDACTED] change .Additionally, there is irregularity along the distal most aspect of the fifth distal phalanx (toe). If there is ulceration/infection in this region as well, this too could relate to early osteo[DIAGNOSES REDACTED] change . Review of the facility's wound notes for Resident #4 failed to reveal any documentation pertaining to a wound on Resident #4's right foot. Further review of Resident #4's medical chart revealed that daily skilled charting was completed for Resident #4. Review of the Skin/Wound Section of these assessments, specifically the type and location section, revealed, Bilateral heels on 1/27/20; Bilateral heels on 1/25/20 and right heel on 1/24/20. During an interview on 3/11/20 at 2:40, wound nurse, Registered Nurse (RN) G stated that she was not aware of a wound on Resident #4's right heel.
F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235504	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE OASIS AT ADRIAN REHABILITATION AND NURSING CTR	**130 SAND CREEK HWY ADRIAN, MI 49221**

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 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) This citation pertains to intake MI 117. Based on interview, and record review, the facility failed to provide medically related social services after a resident to resident abuse incident for two residents (Resident #1 and #2) of two reviewed for social services resulting in the potential to not attain or maintain the highest practicable physical, mental, and psychosocial well-being and diminished quality of life. Findings include: Review of the facility's resident to resident abuse investigation revealed the following: On 12/21/19 approximately 2:30 p.m. residents where gathering for an activity. The activity aide was present and witnessed the two residents (Residents #1 and #2) swearing at each other. (Resident #1) was sitting at a table waiting and (Resident #2) propelled his chair to close to (Resident #1). (Resident #1) began to swear at (Resident #2) and he responded back with similar language. As the activity aide was removing (Resident #2's) chair and separate the two, (Resident #1) swung with open hand and slapped (Resident #2) in the face. This writer (Nursing Home Administrator (NHA) A) can sustain that the altercation did occur between (Resident #1 and #2), it was witnessed and the activity aide attempted to remove and safeguard the resident. Review of Resident #1 and Resident #2 medical records, failed to reveal any documentation that medically related social services were provided to these residents following the resident to resident abuse incident. During an interview on 3/12/20 at 3:05 p.m., when asked about the residents not receiving any type of social services follow up, Social Worker (SW) D stated, I did meet with them, and I think they were in good moods and neither of them had recollection of the incident, they did not seem to have any concerns. When asked if these meetings were documented, SW D looked in the medical record and stated, If I did not put a progress note, I might have put something in their psych services notes. She then looked into the psych services note and said, Normally I do (document). I don't see any in here.