STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235164	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE RIDGE - A REHABILITATION AND NURSING CENTER	**4368 CLEVELAND AVE STEVENSVILLE, MI 49127**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citaion pertains to intake number MI 277. Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 2 of 6 sampled residents (Resident #100, Resident #102) reviewed for care planning, resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 1: Resident Assessment Instrument (RAI) revealed .The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being . The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status . Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 2: Assessments for the Resident Assessment Instrument (RAI), revealed .the resident ' s care plan must be reviewed after each assessment .and revised based on changing goals, preferences and needs of the resident and in response to current interventions .Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan . Review of Resident Care Plan & Assessment reviewed/revised last on 01/2020, revealed, .It is the policy of Pine Ridge to provide care to attain the highest practicable physical well-being of residents in accordance with the comprehensive assessment and plan of care. Care plans are to be developed, reviewed and revised for each resident in our facility per federal and state regulations. B. Care plans reference past life preferences, lifelong habits, diversional activity preferences, likes, dislikes, spiritual needs, etc. Sources are, but not limited to: 1. Problems relating to diagnoses. 2. Problems relating to physician's orders [REDACTED].) 3. Dietary and nutritional status problems. 4. Psycho social well-being problems. 5. Activity problems. 6. Rehabilitation problems. 7. Behavior and mood state problems. 8. Problems related to preventive care. 9. Problems related to provision of safety. 10. All problems that require care. 11. Refusal of care and treatment. 13. Problems related to mental deficits. 14. Problems related to physical deficits. 15. ICD- 10numbers identified for each problem will not be included in the policy. IV. Resident Goals (Short-term Goals) Defined as Problems Less Than 30 Days: A. If concerns, strengths or notes are identified they will be listed under problem statement. V. Interventions: A. List all care to be provided for the problem listed. The care must be necessary and appropriate to accomplish the goal stated. B. Coordinate all care to be provided to the resident for the most effective, efficient utilization of resources. C. Individualize care for the unique needs of the resident. D. Communicate vital information to all staff providing direct resident care. E. List safety measures. F. List approaches to maintain resident's customary routine. G. List preventive measures. H. Standard of care will not be identified and placed on the care plan unless it is specific for the resident's care and provides continuity of care. I. Any changes to the care plan must be done by IDT or designee . Resident #100 Review of the Face Sheet revealed Resident #100 was a [AGE] year-old male, who was originally admitted to the facility on , 04/08/2020 with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 4/14/2020 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15, which indicated Resident #100 was cognitively intact. Review of current Care Plan: for Resident #100, revised on 4/19/2020, revealed the focus, .(Resident #100) is at risk for falling R/T (related to) (Resident #100) is here for skilled care .he requires limited to extensive assistance with ADLs (Activities of Daily Living) . with the intervention .Monitor for pain or discomfort, restlessness or changes in mental status, unsteady gait or decline in mobility .High fall risk, use total life with assist of 1 .Low bed, Foam safety mats on both sides when in bed . Review of Progress Note dated 4/27/2020 at 15:58, Staff Educator/Registered Nurse (RN) C reported, .This nurse heard the resident hollering help and found him laying on the floor next to bed .a bump the size of an egg noted on lt(left) back of head . Review of Progress Note dated 04/27/2020 at 18:08, Registered Nurse M reported, .Foam safety mats were not in place at sides of bed and this nurse replaced the mats to both sides of bed. This nurse then educated floor staff pt (patient) is to have safety mats in place on the floor to both sides of bed when he is in it . Review of Progress Note dated 04/27/20 at 20:10, Registered Nurse M reported, .Care Plan updated to add offer toileting on awakening, before and after meals, and before bed . Review of Progress Noted date 4/27/2020 at 16:53, .Wound Care (Registered Nurse) RN UU notified by Registered Nurse C of fall with injury. Left posterior parietal region of skull: abrasion with ecchymosis r/t (related to) fall with injury. Open, irregular shaped 1.0cm x 1.0cm x 0cm. Wound bed: 100% pink with minimal scattered scabbing. Surrounding skin: ecchymoses, irregular shaped, flat: 4.5cm x 1.5cm x 0cm, purple and blue discoloration, and skin intact. Pt. (patient) denied pain with palpation. Refused application of ice pack. Scant serousangneious drainage present. Absent odor. No apparent signs/symptoms of infection. Treatment: left open to air. Right sclera: bloodshot. Pt.(patient) able to track this RN around the room and able to follow a finger: WNL (within normal limits). Surrounding skin: color appropriate for ethnicity, blanchable, and skin intact. Absent drainage/odor. No apparent signs/symptoms of infection. Treatment: left open to air. Foam mattress appropriate for pt.'s (patient's) current skin condition . During an interview on 07/08/2020 at 12:38 PM, Director of Nursing (DON) B revealed .(Resident #105) did not recognize his limitations, he was not using his call light, and if he fell the impact has been reduced by the safety mat . During an interview on 07/08/20 at 13:04, Physical Therapist HH revealed, Resident #100 was progressing but he was also plateauing as he was not able to get in and out of the bed by himself, his bed mobility included rolling, scooting, bridging, and transiting from lying to sitting .his balance was fair which might predispose him to a fall .he could walk 100-150 feet with close contact guard assist meaning he could walk with a walker, someone close by (holding the gait belt which is around his waist for additional support). Resident #102 Review of the Face Sheet revealed Resident #102 was a [AGE] year-old female, who was originally admitted to the facility on , 05/10/2020 with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 6/17/2020 revealed a Brief Interview for Mental Status (BIMS) score of 8 out of a total possible score of 15, which indicated Resident #102 was moderately cognitively impaired. Review of current Care Plan: for Resident #102, revised on 4/19/2020, revealed the focus, .(Resident #102) is at risk for falling R/T (related to)hospitalization for L (left) femoral neck fracture as a result from GLF (ground level fall) . with the intervention .High risk falls; Low bed Foam safety mats to both sides of bed when she is in it .Frequent checks when she is in her room .Encourage her to remain in supervised area when up . In an observation on 7/8/2020 at 12:07 PM, Resident #102 was observed lying in her bed, bed is not in the low position, and fall

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) mats are not next to her bed on either side. In an observation on 7/9/2020 at 10:58 AM, Resident #102 was observed lying in bed and the bed was not in the low position. During an interview on 7/9/2020 at 01:47 PM, Registered Nurse (RN) R revealed, .When (Resident #102) is up we try to get her outside of her room so we can monitor her more closely .We check on them more often when they are high risk of falls .When the shift change tell the CNA (certified nursing assistant) how she is doing and if there is any special instructions and if any changes to report to the nurse . In an observation on 7/10/2020 at 11:04 AM, Resident #102 is observed in bed, bed is not in low position. Fall mat is not on the left side of the bed by the privacy curtain. In an observation on 7/10/2020 at 11:40 AM, Resident #102 fall mat is still not on the left side of the bed. Bed is not in the low position. In an observation on 7/10/2020 at 12:57 PM, Resident #102 was observed lying in her bed, fall mat was placed on the right side of the bed but not on the left side of the bed, and Resident #102's bed was not in the low position. During an interview on 7/10/2020 at 01:00 PM, Certified Nursing Assistant (CNA) OO revealed Resident #102 did not have fall mats on the left side or the right side of her bed, the bed was not in the low position. CNA OO reported she is the CNA assigned to Resident #102 on this date. During an interview on 7/10/2020 at 01:00 PM, Certified Nursing Assistant (CNA) OO revealed she would look in the electronic medical record for the care plan interventions which should be in place for Resident #102 while she is in bed.
F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citaion pertains to intake number MI 277. Based on interview and record review, the facility failed to provide cardiopulmonary resuscitation (CPR) per the advanced directives in 1 of 6 residents (Resident #100) reviewed for advanced directives , resulting in an immediate jeopardy when, on [DATE] at approximately 6:25 AM, Resident #100 who was a full code, was found without a detectable pulse or respirations, CPR was not initiated, a call to 911 alerting Emergency Medical Services was not placed, and Resident #100 was pronounced deceased by facility nursing staff. This deficient practice placed 32 additional residents, identified as a full code, at risk for serious harm and/or death. Findings include: On [DATE] at 03:50 P.M. the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy that began on [DATE] and was identified on [DATE] due to the facility's failure to adequately monitor, assess, and perform cardiopulmonary resuscitation (CPR) on Resident #100. A written plan for removal for the immediate jeopardy was received on [DATE] and the following was verified on [DATE]. 1. On [DATE], Cardiopulmonary Resuscitation (CPR) Policy revised, and changes made to reflect that CPR is to be initiated until the arrival of emergency medical services. 2. The two RNs that did not provide CPR were re-educated on the new CPR policy for Full Code residents. One in person by the Director of Nursing (DON) and the other one via phone again by the DON to start performing CPR if the resident is a full code until the arrival of emergency medical services. 3. Re-education of all licensed nurses (30) except for those on vacation or a leave of absence (3) has been initiated by Staff Educator, RN on CPR regulations as well as the new policy and procedure (as of [DATE]). Nurses present in the building (10) signed physical copies of the attestation. Re-education for all nurses on the new policy will be completed by the end of the day Monday [DATE]. Education includes location of code status for each resident. Licensed nurses on vacation or leave of absences will not be allowed to work until educated and an attestation is signed. 4. Certified Nursing Assistant (CNA) education to call a nurse immediately if a resident is not responding will be completed by noon on [DATE]. 5. Beginning [DATE] new hires (licensed nurses) will be educated on CPR regulations as well as the updated facility policy and procedure, accordingly. 6. On [DATE], an initial CPR certification audit revealed that ,[DATE] licensed nurses hold current certification. There is a CPR certified nurse available for each shift. 7. A Quality Assurance Performance Improvement (QAPI) Performance Improvement audit will be implemented to monitor for compliance. This audit will begin on [DATE]. DON/designee to monitor for code status compliance by interviewing licensed nurses weekly about facility CPR policy and procedure for a month. 8. Beginning [DATE] the DON/designee will audit new admissions to compare the resident's advance directives to the electronic record weekly on an ongoing basis and until a date determined by the QAA Committee meeting. 9. [DATE]- A DON designee completed a chart audit on all residents and compared advance directives to the electronic record that is used for nurses to check code status. Two inaccuracies were identified and rectified. 10. Person responsible for compliance will be the Director of Nursing or designee. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of 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 policy and procedure CPR-Cardiopulmonary Resuscitation Policy revised on ,[DATE], revealed, .It is the policy of this facility will provide basic life support, including CPR - Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order [REDACTED]. valid document expressing the resident's wishes to not be resuscitated. o Resident presents with obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection or decomposition) are present o Initiating CPR could cause injury or peril to the rescue . Review of the Face Sheet revealed Resident #100 was a [AGE] year-old male, who was originally admitted to the facility on , [DATE] with pertinent [DIAGNOSES REDACTED]. Review of the Advanced Care Planning document dated [DATE], revealed Resident #100 indicated he wanted cardiopulmonary resuscitation (CPR) performed to maintain life support. Review of Advance Care Plan/Power of Attorney for Healthcare dated [DATE], revealed, Resident #100 initialed, .If my heart of breathing stops .I want CPR in all cases .Advanced Interventions: Use intubations, advanced invasive airway interventions, mechanical ventilation, cardioversion, and other advance interventions as medically indicated. Transfer to hospital if indicated; includes intensive care . During an interview with Social Worker JJ and Social Worker II on [DATE] at 12:03 PM, reported Resident #100 was indeed a Full Code. Social Worker II reported this designation can be determined by the notation on the Face Sheet in the electronic medical record and on the hard chart there is a sticker if they are designated as a Do Not Resuscitate (DNR). During an interview on [DATE] at 10:53 AM, Certified Nursing Assistant (CNA) BB reported she was going around and checking the vitals of the residents and went into room [ROOM NUMBER] to check those of Resident #100. Resident #100 was observed on the floor and he looked as if he was sleeping and upon further observation noticed he was not breathing. CNA BB reported she went to find someone to assist and had Registered Nurse (RN) J come to assist. During an interview on [DATE] at 11:58 AM, Registered Nurse (RN) J reported when she found Resident #100 and he looked as though he attempted to stand up and his feet had went out under him as she believed Resident #100 slipped on the bowel movement which was on the floor under Resident #100. RN J reported she checked the carotid artery and asked Certified Nursing Assistant BB to find Licensed Practical Nurse (LPN) L. RN J reported she did not perform cardiopulmonary resuscitation on Resident #100. Registered Nurse (RN) J reported RN F and Licensed Practical Nurse (LPN) L came to Resident #100's room and assisted with the response. During an interview on [DATE] at 12:55 PM, RN F reported he was providing report to the oncoming nurse Licensed Practical Nurse L when he was alerted to respond to Resident #100's room. Registered Nurse (RN) F reported they did not perform cardiopulmonary resuscitation (CPR) on Resident #100 and he was pronounced deceased . During an interview on [DATE] at 01:54 PM, Director of Nursing (DON) B reported, .If you (Nursing staff) walk in and they might still be breathing, start cardiopulmonary resuscitation (CPR), and call 911. If they (Resident) appear to have been dead for a while and they are no longer breathing, you pronounce them and start the notification of the family, provider, and funeral home. In this case with (Resident #100), the two nurses pronounced him dead at that time . DON B reported, .With them being professionals and using their judgement they felt he (Resident #100) had been dead for a while and CPR was not going to be effective . During an interview on [DATE] at 12:27 PM, Licensed Practical Nurse (LPN) L reported, .(Resident #100) was observed sitting on the floor, leaning against the bed, he didn't appear to be breathing . Licensed Practical Nurse (LPN) L reported, Registered Nurse (RN) F and RN J performed the assessment on him. LPN L reported she left and made the phone calls to the Nurse Practitioner EE and the Medical Examiner. LPN L reported they did not perform cardiopulmonary resuscitation (CPR) on Resident #100. Review of Investigative Report completed by(NAME)Knapp, Berrien County reported, Facility reported (Resident #100) was last seen approximately 0445 this am then was found deceased by CNA around 0625am .RN pronounced death at 0625 am (Resident #100) was pronounced deceased by facility staff .room was cleaned and decedent was lying on his back on the bed prior to my arrival .(Resident #100) was cool to the touch .Rigor Mortis was not present .Livor Mortis was slight and consistent with the position (Resident #100) was in on my arrival . Review of CPR Certified Staff document provided on [DATE] of those nursing staff trained to perform cardiopulmonary resuscitation (CPR) revealed Registered Nurse J and Licensed Practical Nurse L were not CPR certified on [DATE]. Review of Recent expired CPR license of PR (Pine Ridge) nursing staff provided on [DATE]

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F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) revealed, Registered Nurse J and Licensed Practical Nurse L were not included in those allowed an exemption during the COVID-19 outbreak.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citaion pertains to intake number MI 277. Based on interview and record review, the facility failed to maintain a safe environment to prevent falls in 1 of 6 sampled residents (Resident #100) reviewed for falls, resulting in Resident #100 sustaining multiple falls and the potential for serious injury. Findings include: Review of the Face Sheet revealed Resident #100 was a [AGE] year-old male, who was originally admitted to the facility on , 04/08/2020 with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 4/14/2020 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of a total possible score of 15, which indicated Resident #100 was cognitively intact. Review of Progress Note dated 4/15/2020 at 08:21, revealed, .Resident was found laying on the left side of his bed, he shouted out, but had not used his call light .he tried to go to the bathroom, but forgot that he can't walk . Review of Progress Note dated 4/16/2020 at 19:23, revealed, .Care plan updated to reflect high risk for falls .Low bed .Foam safety mats on both sides of bed when he is in it . Review of current Care Plan: for Resident #100, revised on 4/19/2020, revealed the focus, .(Resident #100) is at risk for falling R/T (related to) (Resident #100) is here for skilled care .he requires limited to extensive assistance with ADLs (Activities of Daily Living) . with the intervention .Monitor for pain or discomfort, restlessness or changes in mental status, unsteady gait or decline in mobility .High fall risk, use total lift with assist of 1 .Low bed, Foam safety mats on both sides when in bed . Review of Progress Note dated 4/27/2020 at 15:58, Staff Educator/Registered Nurse (RN) C reported, .This nurse heard the resident hollering help and found him laying on the floor next to bed .a bump the size of an egg noted on lt (left) back of head . Review of Progress Note dated 04/27/2020 at 18:08, Registered Nurse M reported, .Foam safety mats were not in place at sides of bed and this nurse replaced the mats to both sides of bed. This nurse then educated floor staff pt (patient) is to have safety mats in place on the floor to both sides of bed when he is in it . Review of Progress Noted date 4/27/2020 at 16:53, revealed, .Wound Care (Registered Nurse) RN UU notified by Registered Nurse C of fall with injury. Left posterior parietal region of skull: abrasion with ecchymosis r/t fall with injury. Open, irregular shaped 1.0cm x 1.0cm x 0cm. Wound bed: 100% pink with minimal scattered scabbing. Surrounding skin: ecchymoses, irregular shaped, flat: 4.5cm x 1.5cm x 0cm, purple and blue discoloration, and skin intact. Pt. denied pain with palpation. Refused application of ice pack. Scant serousangneious drainage present. Absent odor. No apparent signs/symptoms of infection. Treatment: left open to air. Right sclera: bloodshot. Pt. able to track this RN around the room and able to follow a finger: WNL. Surrounding skin: color appropriate for ethnicity, blanchable, and skin intact. Absent drainage/odor. No apparent signs/symptoms of infection. Treatment: left open to air. Foam mattress appropriate for pt.'s current skin condition . Review of Progress Note dated 5/7/2020 at 08:55, revealed, .This nurse (Registered Nurse G) heard the resident calling out, upon entering resident's room .resident seem to be confused . During an interview on 07/08/2020 at 12:38 PM, Director of Nursing (DON) B revealed .(Resident #105) did not recognize his limitations, he was not using his call light, and if he fell the impact has been reduced by the safety mat . During an interview on 07/08/20 at 13:04, Physical Therapist HH revealed, Resident #100 was progressing in therapy but he was also plateauing as he was not able to get in and out of the bed by himself, his bed mobility included rolling, scooting, bridging, and transiting from lying to sitting .his balance was fair which might predispose him to a fall .he could walk 100-150 ft with close contact guard assist meaning he could walk with a walker, someone close by (holding the gait belt which is around his waist for additional support). During an interview on 07/09/2020 at 10:12 AM, Certified Nursing Assistant (CNA) V reported Resident #100 always tried to get up and had to watch him as he was spontaneous. Resident #105 was confused at times, sometimes he didn't make sense with what he was saying. Certified Nursing Assistant (CNA) V reported there was a couple times she wrote a behavioral sheet on Resident #100 because of his confusion. During an interview on 07/09/2020 at 11:15 AM, Licensed Practical Nurse (LPN) D reported they have done 15/30 minute checks on someone if they have fallen and are a high fall risk. LPN D reported staff also have them come sit close to the desk area so they are able to keep a closer eye on them. During an interview on 7/9/2020 at 11:46 AM, Certified Nursing Assistant (CNA) CC reported the CNAs are able to see the care needs of residents when they log into the electronic medical records. CNAs don't do a lot of documentation in the computers, they verbally inform the nurses of their observations of the residents. During an interview on 07/09/2020 at 01:47 PM, Registered Nurse (RN) R reported the staff check on them more often and if they are a high fall risk they get them up and put them in closer supervised areas. RN R reported information is shared during shift change with the CNAs and if there is any special instructions for residents. During an interview on 07/09/2020 at 11:59 AM, Registered Nurse (RN) M revealed, .If I see something happening and of course we always err on the side of caution .I always try to see what else I can do for this person .each are unique and have their own patterns and I always try to be considerate and anticipate their needs. In that situation and looking like he had to go potty and his need to get up to go potty as that was part of it, frequent checks are always a good thing , but in hindsight I should have placed him on frequent checks . Review of a current Care Plan: for Resident #102, revised on 4/19/2020, revealed the focus, .(Resident #102) is at risk for falling R/T (related to)hospitalization for L (left) femoral neck fracture as a result from GLF (ground level fall) . with the intervention .High risk falls; Low bed Foam safety mats to both sides of bed when she is in it .Frequent checks when she is in her room .Encourage her to remain in supervised area when up . During an interview on 07/10/2020 at 02:42 PM, Director of Nursing (DON) B reported the nurses are the professionals and they are the ones responsible for the documentation in the medical record. Nurses will obtain information from the certified nursing assistants and use this information in the narrative charting.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citaion pertains to intake number MI 277. Based on observation, interview, and record review, the facility failed to implement infection control practices related to hand hygiene and droplet precautions creating unsanitary conditions for 2 residents (Resident #105, Resident #104) reviewed for infection control practices from a total sample of 6 residents, resulting in the potential for the spread of infections, cross-contamination, and disease transmission which placed a vulnerable population at risk. Findings include: Review of Infection Prevention and Control: Droplet Precautions reviewed on 07/2019, revealed, .Entering the Room: Perform hand hygiene, wear all of the following personal protective equipment (PPE) Gown, Mask, Gloves, As well as other PPE (such as eye protection, if needed due to the risk of splashing .Exiting the Room: Remove gown, mask, gloves, and discard Perform hand hygiene . Review of Infection Prevention and Control Plan LTC reviewed on 8/2019, revealed. .4. Hand Hygiene Protocol: 4.1. All staff shall perform hand hygiene when coming on duty, between resident contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty. 4.2. Staff shall perform hand hygiene before and after performing resident care procedures. 4.3. Hand hygiene will be performed in accordance with the corporate Hand Hygiene policy . Upon entry on 7/7/2020, Director of Nursing (DON) B reported the rooms to the right of the main entry (100 hallway) are specifically used for those individuals admitted from the hospital and are placed on droplet isolation precautions. Resident #105: Review of the Face Sheet revealed Resident #105 was a [AGE] year-old male, who was originally admitted to the facility on , 07/02/2020 with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 6/17/20, revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #105 had moderate cognitive impairment. Review of current Care Plan: for Resident #105, revised on 7/3/2020, revealed the focus, .(Resident #105) is here for [MEDICAL CONDITION] and [MEDICATION NAME] hemorrhage resulting in left side paralysis .continuous [MEDICAL CONDITION] with 3 Liter of O2 (oxygen) at all times with the intervention at risk for falling R/T (related to) (Resident #100) is here for skilled care .he requires limited to extensive assistance with ADLs (Activities of Daily Living) . with the intervention .HOB (head of bed) at or below 30 degree angle .pressure relief cushion in w/c (wheelchair) . In an observation at the entrance to Resident #105's room was posted the Isolation Precautions Education sheet which shows the proper personal protective equipment (PPE) that are required prior to entering the resident's room. This posting showed in written and image form the required use of a facial mask, face shield/goggles, gown, and gloves. In an observation on 7/9/2020 at 10:28 AM, Certified Nursing Assistant (CNA) Z entered Resident #105's room and was not observed to perform hand hygiene nor don a gown. CNA Z assisted Resident #105 with

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PINE RIDGE - A REHABILITATION AND NURSING CENTER	**4368 CLEVELAND AVE STEVENSVILLE, MI 49127**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) adding water to his [MEDICAL CONDITION] machine which was laying on his rolling bedside table next to Resident #105's bed, handling the machine to open, the gallon jug of sterilized water, and added the sterilized water to the machine. During an interview on 7/9/2020 at 10:35 AM, Certified Nursing Assistant (CNA) Z reported he did not don a gown when he was in Resident #105's room. CNA Z' revealed, .(CNA Z) knew I wasn't going to touch him .I was assisting with adding water to his machine . During an interview on 7/14/2020 at 10:35 AM, Registered Nurse (RN) I reported she would perform hand hygiene, put a gown on, put on gloves and ensure she had a face shield prior to entering the room. RN I is currently wearing a face mask as this is a requirement at this facility. During an interview on 7/14/2020 at 10:43 AM, Certified Nursing Assistant (CNA) DD reported droplet precautions require her to perform hand hygiene, don a gown, put on gloves and face shield or goggles prior to entering the resident's room. During an interview on 7/14/2020 at 10:50 AM, Staff Educator, RN C reported when a resident is admitted they are placed on 14 days isolation precautions. Staff Educator, RN C reported we recently completed education with the staff. Staff watched a video in My Learning and we have completed audits for infection control looking at hand hygiene, precautions, and the appropriate use of personal protective equipment (PPE). Staff Educator, RN C reported staff should be aware of the requirements for precautions. Resident #104 Review of the Face Sheet revealed Resident #104 was a [AGE] year-old male, who was originally admitted to the facility on , 07/02/2020 with pertinent [DIAGNOSES REDACTED]. Review of current Care Plan: for Resident #104, revised on 07/02/2020, revealed the focus, .(Resident #104) is here for increased leg swelling/blistering, new onset of A-Fib, [MEDICAL CONDITIONS] exacerbation with borderline [MEDICAL CONDITION] vascular congestion, ground level fall, and [MEDICAL CONDITION](presence of gas in the bladder wall) . with the intervention .Requires reminders to turn in bed .verbal reminders not to ambulate/transfer without assistance .monitor for changes in mental status, unsteady gait or decline in mobility .pleasantly confused and forgetful . Upon entry on 7/7/2020, Director of Nursing (DON) B reported the rooms to the right of the main entry (100 hallway) are specifically used for those individuals admitted from the hospital and are placed on droplet isolation precautions. In an observation at the entrance to Resident #104's room was posted the Isolation Precautions Education sheet which shows the proper personal protective equipment (PPE) that are required prior to entering the resident's room. This posting showed in written and image form the required use of a facial mask, face shield/goggles, gown, and gloves. In an observation on 7/10/2020 at 02:28 PM, Housekeeper SS was in Resident #104's room with no gown on, mask pulled down to expose her nose, and no face shield/goggles. During an interview on 7/10/2020 at 02:30 PM, Housekeeper SS reported she did not have on a gown or face shield/goggles. Housekeeper SS reported she understood the droplet precautions posting outside Resident #104's room but did understand why staff members who utilized proper PPE still had tested positive for COVID-19 and questioned the use of the required PPE. In an observation 7/10/2020 at 02:33 PM, Housekeeper SS was observed not utilizing proper hand hygiene prior to donning new gloves after her exit from Resident #105's room nor donning a face shield/goggles necessary prior to her entrance to the room with droplet precautions. During an interview on 7/10/2020 at 02:37 M, EVS/Maintenance Manager KK reported the housekeeping staff were in-serviced via Net Learning on the requirements for personal protective equipment (PPE) for droplet precautions. EVS/Maintenance Manager KK reported his staff were given handouts as well on the types of precautions and the necessary PPE and for proper sanitization. During an interview on 7/14/2020 at 10:35 AM, Registered Nurse (RN) I reported she would perform hand hygiene, put a gown on, put on gloves and ensure she had a face shield prior to entering the room. RN I is currently wearing a face mask as this is a requirement at this facility. 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