STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235561	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARIA NURSING AND REHAB	707 ARMSTRONG LANSING, MI 48911

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 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 025. Based on interview and record review the facility failed to provide care and services that met Professional Standards of Quality, failed to follow physician orders [REDACTED]. Findings include: Nurses must obey the orders of the physician in charge of a patient, unless an order would lead a reasonable person to anticipate injury if it were carried out, according to Creighton in Law Every Nurse Should Know, 5th Edition, page 98. The nurse is obligated to follow the physician's orders [REDACTED]. (Fundamentals of Nursing, Concepts, Process, and, Practice, Mosby, Perry, P., Potter, A., 1985). Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R4 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R4 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required one person set up assist with bed mobility, dressing, hygiene, and bathing. Review of intake M 025, submitted to the State of Michigan on 8/14/20, reflected, (named R4) was scheduled for a colonoscopy which had to be rescheduled because the home staff did not prep him correctly. The rescheduled colonoscopy is scheduled for today and (named R4) is going to be given the colonoscopy; however, he is still not prepped correctly by the home staff. (Named R4) got teary today and said, They don't take care of me. During a telephone interview on 9/2/20 at 1:49 p.m., complainant D verified M 025 intake information and expressed satisfaction that R4's care was being reviewed. During an interview and observation on 9/2/20 at 2:24 p.m., R4 was noted to live on the Covid-19 observation hall for residents exposed to outside community with isolation signs in place and door closed. R4 was talking on phone upon entering the room with [MEDICAL CONDITION] noted. R4 appears well groomed with no odors noted in room. R4 reported felt safe in facility but expressed very unhappy about being quarantine to room only for 14 days. R4 verified recent colonoscopy and reported drank medication night prior to scheduled procedure but unsure of details. R4 reported ongoing issues with constipation. Review of the [MEDICATION NAME] Physician Consult orders, dated 3/3/20, reflected R4 was given orders for a colonoscopy scheduled for 3/11/20 at 11:15 a.m. The colonoscopy prep orders included; stop aspirin 3/6/20, stop taking iron supplements five days prior to procedure, clear liquid diet day prior to procedure, take [MEDICATION NAME] tablet with 8oz. of water at 12:00 p.m. on day prior to procedure, mix [MEDICATION NAME]/NuLytely with 1 gallon of water and drink half of the mixture (8oz. every 10-15 minutes for a total of 8 glasses) within 1.5 hours at 6:00 p.m. on day prior to procedure. Six hours prior to procedure drink remaining half of [MEDICATION NAME]/NuLytely solution. Prep must be completed 4.5 hours prior to procedure. The orders indicated failure to follow orders would result in cancellation of appointment. The orders reflected hand written note, FYI-will input orders if ok? signed Registered Nurse Unit Manager (RN/UM) L and OK TY signed by Physician Assistant. Review of the facility Medication Administration Order(MAR), dated 3/1/20 through 3/31/20, reflected R4 did not receive any of the colonoscopy prep orders reflected on the signed [MEDICATION NAME] Physician Consult orders dated 3/3/20. Review of the facility Physician orders, dated 3/1/20 through 3/31/20, reflected no colonoscopy prep orders for the scheduled colonoscopy on 3/11/20. Review of the facility Electronic Medical Record(EMR) including the Progress Notes, dated 3/1/20 through 3/31/20, reflected no documentation about scheduled colonoscopy for 3/11/20 including possible reason to reschedule. Review of the [MEDICATION NAME] Physician Consult orders, dated 7/21/20, reflected R4 was given orders for a colonoscopy scheduled for 8/14/20 at 8:45 a.m. The colonoscopy prep orders included; stop taking iron supplements five days prior to procedure, clear liquid diet day prior to procedure, take [MEDICATION NAME] tablet with 8oz. of water at 12:00 p.m. on day prior to procedure, mix [MEDICATION NAME]/NuLytely with 1 gallon of water and drink half of the mixture (8oz. every 10-15 minutes for a total of 8 glasses) within 1.5 hours at 6:00 p.m. on day prior to procedure. Six hours prior to procedure drink remaining half of [MEDICATION NAME]/NuLytely solution. Prep must be completed 4.5 hours prior to procedure. The orders indicated failure to follow orders would result in cancellation of appointment. The orders reflected, entered 7/21/20 1335. Review of the facility MAR, dated 8/1/20 through 8/31/20, reflected R4 received Aspirin 325mg 8/1/20 through 8/13/20. The MAR reflected R4 had an order that reflected, NuLytely with Flavor Packs Solution Reconstituted 420 GM (PEG 3350-KCl-Na [MEDICATION NAME]-NaCl) Give 420 gram by mouth one time only for procedure prep for 1 Day At 1800 on 8/13 drink 1/2 of solution within 1.5 hours. Then at midnight drink the other half within 1.5 hours and appeared as administered on 8/13/20 as evidenced by initials and reflected a hole(blank) in documentation on 8/14/20. During a telephone interview on 9/3/20 at 11:24 a.m., Licensed Practical Nurse (LPN) N reported she had worked 12 hour night shift on 8/13/20 with R4. LPN N reported R4 did not get NuLytely prep at 1800 but started by 1900. LPN reported NuLytely powder was mixed with one gallon on water and R4 was given half of the gallon solution and she encouraged R4 to finish by midnight. LPN reported order was only for 1/2 of 1 gallon mixture and NPO after midnight and that is what she did. During an interview on 9/3/20 at 12:28 p.m., RN/UM L reported working at the facility since January. RN/UM L reported the facility process for consults was that the nurse would receive paperwork from consults and would add note, contact house physician to verify any orders, schedule any follow up appointments including transportation, then adds orders to facility EMR. RN/UM L verified 3/3/20 consult orders had her signature and reported was unsure why no orders for R4 colonoscopy prep for 3/11/20 were located in EMR or on MAR. RN/UM L reviewed R4 August MAR and reported appeared second half of R4 prep not given and reported R4 should have received 1 full gallon of NuLytely for colonoscopy prep. During an interview on 9/3/20 at 3:15 p.m., RN/UM L reported R4 went for colonoscopy on 3/11/20 and they were unable to perform related to prep not given as ordered. RN/UM reported when R4 returned from GI appointment on 3/3/20 with orders process should have been to have physician review then nurse add orders into EMR. RN/UM Lreported as the unit manager it was her responsibility to followed up but was unsure how it was missed and reported had only been at facility for just over a month at that time. RN/UM L reported the R4 missed March colonoscopy had to be rescheduled and was unable get rescheduled related to onset of Covid-19 Pandemic until August(five months later). RN/UM L reported R4 had colonoscopy 8/14/20 and reported MAR had two places to document for prep but nurse only required to document in one as second was as a safe guard.

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.