STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235442	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREAT LAKES REHAB CENTER	4180 TITTABAWASSEE ROAD SAGINAW, MI 48604

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 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to MI 064. Based on interview and record review, the facility failed to complete and transmit federally required Minimum Data Set Assessments in a timely manner for five residents (Resident #30, Resident #33, Resident #34, Resident #35, and Resident #36) out of six residents reviewed for timeliness of assessments resulting in the potential for inaccurate tracking of residents assessments, discharges, admissions, and transfers. Findings include: During an interview with the Registered Nurse (RN) A, who stated that she was responsible for completing the Minimum Data Set Resident Assessments (MDS) for the facility residents on 3/9/2020 beginning at 1:20 PM, RN A stated that she was solely responsible for MDS completion. RN A stated that she did the MDS for the newly admitted residents first then did the quarterlies and discharge assessments. RN A stated that the MDS must be transmitted to the Centers for Medicare and Medicaid Services 14 days from the Assessment Reference Date. According to the Admission Record, printed on 3/9/2020, Resident #30 had been admitted to the facility on [DATE] and discharged on [DATE]. Resident #30 had a MDS discharge assessment open in the Electronic Medical Record (EMR). The Assessment Reference Date (ARD) was 2/14/2020. The status of the MDS was listed as in progress. The MDS screen showed that the MDS was 10 days overdue. RN A agreed that the transmission of the MDS for Resident #30 was late. According to the Admission Record, printed on 3/10/2020, Resident #33 had been originally admitted to the facility on [DATE] and discharged on [DATE] with a readmission on 3/1/2020. Resident #33 had a MDS discharge assessment open in the Electronic Medical Record (EMR). The Assessment Reference Date (ARD) was 2/25/2020. The status of the MDS was listed as in progress. The MDS was four days overdue. According to the Admission Record, printed on 3/10/2020, Resident #34 had been admitted to the facility on [DATE]. Resident #34 had a MDS quarterly assessment open in the Electronic Medical Record (EMR). The ARD was 2/5/2020. The status of the MDS was listed as in progress. The MDS screen showed that the MDS was 19 days overdue. According to the Admission Record, printed on 3/10/2020, Resident #35 had been admitted to the facility on [DATE]. Resident #35 had a MDS 5 day admission assessment open in the Electronic Medical Record (EMR). The ARD was 2/25/2020. The status of the MDS was listed as export ready. According to the Admission Record, printed on 3/10/2020, Resident #36 had been admitted to the facility on [DATE]. Resident #36 had a MDS quarterly assessment open in the Electronic Medical Record (EMR). The ARD was 1/22/2020. The status of the MDS was listed as in progress. The MDS screen showed that the MDS was 33 days overdue.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to MI 501. Based on interview and record review, the facility failed to develop a care plan to meet the immediate care needs of one resident (Resident #31) within 48 hours of admission out of two residents reviewed for baseline care plans resulting in the potential for a lack of coordination of care between facility and hospice staff. Findings include: According to the Admission Record, printed on 3/9/2020, Resident #31 was an [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Admission Record and the Census on the electronic medical record, printed on 3/9/2020, Resident #31 was admitted to the facility under hospice care. The baseline care plan developed for Resident #31 on 2/19/2020 did not include a focus for hospice care. There was no contact number for the hospice agency or hospice nurse in the plan of care. There were no hospice goals for meeting spiritual or emotional needs for Resident #31 or her family. The facility policy for Care Plans - Baseline, dated as reviewed 7/2019, instructed that To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. The policy directed that The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to : if applicable a. Initial goals based on admission orders [REDACTED]. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
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 Citation pertains to MI 064. Based on interview and record review, the facility failed to develop and implement a person-centered, individualized comprehensive care plan for one resident (Resident #30) out of two residents reviewed for care planning resulting in the potential for a lack of consistent, person-centered care by all staff. Findings include: According to the Admission Record, Resident #30 was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview with the Physical Therapist (PT) D on 3/9/2020 beginning at 10:00 AM, who had treated Resident #30 during his stay at the facility, she stated that she participated in the development of care plans for residents who received therapy. PT D stated that the therapy documentation was a separate system from the facility electronic medical record. PT D provided both the Occupational Therapy (OT) evaluation and the PT evaluation and treatment records. According to the Physical Therapy - PT Evaluation & Plan of Care, documentation, Resident #30 was assessed as requiring PT six times a week for 12 weeks. Resident #30 had refused OT. Resident #30 had no comprehensive care plan in the facility electronic medical record (EMR) that addressed his PT needs and treatment. The care plan for Resident #30 for an activities of daily living self-care performance deficit related to Impaired Balance, initiated on 1/25/2020, had an intervention of PT/OT evaluation and treatment as per MD (medical doctor) orders. There was no specific focus for the PT Resident #30 had received or the goals for PT treatment on the care plan in the EMR. According to the facility policy for Care Plans, Comprehensive Person-Centered, dated as reviewed 7/2019, the comprehensive person-centered care plan was to describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During the interview with PT D on 3/9/2020 beginning at 10:00 AM, she stated that Resident #30 did have adaptive silverware so he was able to feed himself. During an interview with the Chef E, on 3/10/2020 beginning at 11:00 AM, he stated that the spouse of Resident #30 had brought the adaptive silverware for him to be used to enable him to feed himself. Chef E stated that the adaptive silverware needed to be strapped to his left hand before the meal. The use of the adaptive silverware was not on the care plan. The care plan for Resident #30 for an activities of daily living

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) self-care performance deficit related to Impaired Balance, initiated on 1/25/2020, stated under the interventions section that Resident #30 was totally dependent on one staff member for eating.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to MI 501. Based on interview and record review, the facility failed to manage the pain of one resident (Resident #31) out of two residents reviewed for pain management resulting in the potential for uncontrolled pain. Findings include: According to the Admission Record, printed on 3/9/2020, Resident #31 was an [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The physician Order Summary, printed on 3/9/2020, listed the following medications were prescribed for Resident #31 on the date of admission, 2/19/2020, [MEDICATION NAME] tablet (Tylenol), give 500 milligrams (mg) every six hours as needed, Celecoxib capsule (a non-steroidal anti-[MEDICAL CONDITION]) 100 mg one time a day, [MEDICATION NAME] 12 micrograms (mcg) per hour patch, apply one patch every 72 hours, and [MEDICATION NAME] (usually prescribed for [MEDICAL CONDITION] arthritis) one 200 mg tablet once a day on odd days and 400 mg on even days for lupus. The hospital discharge Medication list, printed on 2/19/2020 at 10:20 AM and scanned into the electronic medical record, revealed that the [MEDICATION NAME] 12 mcg per hour patch had been applied on 2/17/2020 at 12:36 PM and was due to be re-applied on 2/20/2020. On 2/19/2020 at 2:57 PM, Resident #31 was screened for pain during the admission assessment. The pain level was determined to be zero. The list of medications for pain was left blank. Resident #31 was assessed for pain on 2/19/2020 at 11:30 PM through a Staff Assessment for Pain. The assessment recorded Non-verbal sounds of calls out frequently. No facial grimacing noted. Not able to respond verbally. Resident #31 was administered Tylenol 500 milligrams (mg) which was noted to be ineffective on the February 2020 Medication Administration Record [REDACTED]. The follow-up pain scale, recorded in the progress notes on 2/20/2020 at 6:19 AM was 2. The [MEDICATION NAME] 12 mcg per hour patch had been due to be re-applied on 2/20/2020 at 12:36 PM, the MAR indicated [REDACTED]. There was no record that the [MEDICATION NAME] been dispensed from the pharmacy. [MEDICATION NAME]es, in the strengths of 12 mcg and 25 mcg per hour, were on the list of medications available in the back-up box supply. The Registered Nurse (RN) C from the hospice agency visited 2/20/2020 beginning at 5:29 PM, five hours after the [MEDICATION NAME] was due to be replaced. The hospice RN C noted the presence of a 12 mcg [MEDICATION NAME] on the left upper arm. The hospice RN C assessed Resident #31's pain as 7 of 10 and included the behaviors of occasional moan or groan, facial grimacing and fidgeting. The hospice RN C was unable to assess Resident #31's verbal description of pain due to (patient's) condition. The hospice RN C notified the physician and got an order to increase the dose of [MEDICATION NAME] to 25 mcg per hour. The hospice RN C was unavailable for an interview. The RN hospice supervisor B was interviewed by telephone on 3/10/2020 beginning at 9:10 AM. RN B was asked if there was a date on the [MEDICATION NAME] on Resident #31 and why the dose was increased rather than the [MEDICATION NAME] been replaced with a new dose. RN B said he could not speak to that since he had not seen Resident #31 nor had he been involved in the conversation. According to the February 2020 MAR for Resident #31, the [MEDICATION NAME] 25 mcg per hour patch was applied 2/21/2020 at 5:13 AM and a pain level of three was assessed. Resident #31 had a care plan in place with a focus of pain related to [MEDICAL CONDITION]. The first intervention was to administer medication for pain according to the physician orders. The [MEDICATION NAME] 12 mcg per hour had not been administered as ordered because the patch was not replaced in 72 hours.