STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235703	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR NURSING & REHAB CENTER LLC	50 N PERRY ST, 1ST FOOR PONTIAC, MI 48342

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 0577 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation, interview, and record review, the facility failed to inform residents of the location of the Survey Book for 3 out of 3 residents who attended the Confidential Group meeting; resulting in residents to be uninformed of the facility's deficient practices, and the impediment of residents' rights. Findings Include: On 9/22/20 at 3:30 p.m., during the Confidential Group meeting, when asked if residents knew where the facility's State Survey results for prior surveys were kept, 3 out of 3 residents did not know what the State Survey report was or where it was located. On 9/22/20 at 4:05 p.m., during an interview with the Director of Nursing (DON), when asked where the facility's State Survey binder was located, the DON stated, It should be in the dining room area. At that time, an observation of the dining room was made. The State Survey results were not found. Further observation revealed the State Survey binder was on a desk in the lobby area near the receptionist. When queried how residents would know where to find prior survey results, and if there was a sign in the area behind the double doors (where residents resided) that would direct the residents to the facility's State Survey results, the DON did not have an explanation. On 9/22/20 at 4:20 p.m., an interview was conducted with the Administrator. When asked about the facility's Activities Director, the Administrator reported the Activities Director no longer worked at the facility, and she was conducting the Resident Council meetings. When queried where the facility's State Survey results were posted for the residents' review, the Administrator stated, I really didn't know I was supposed to. I should have in-serviced the residents and remind them where the book is. I should have talk to the president and vice president to guide the other residents. Review of the facility's policy titled Survey Results, Examination revised 9/22/20 read in part as follows: Policy Interpretation and Implementation .2. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room .
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate documentation prior to initiating a change, or verification of a code status desire for Do Not Resuscitate (DNR) order that included specific evidence that the legal guardian had attempted to consult with the resident about withholding treatment if possible, and that the attending physician had consulted directly with the legal guardian to affirm and/or reaffirm to identify the specific medical indications that may warrant the DNR order for one (R2) of two residents reviewed for advance directives, resulting in the potential for increased likelihood for the resident's end of life wishes and preferences not being considered and/or honored. Findings include: A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition (scored ,[DATE] on the Brief Interview for Mental Status Exam). A review of the current electronic clinical record revealed R2's code status was DNR. A facility form revealed the DNR had been signed by R2's legal guardian on [DATE]. The physician signed the form but there was no date of when this was completed. Additionally, the current guardianship letter had expired. A review of R2's physician orders [REDACTED]. The current DNR order was not initiated until [DATE] which read, Advance Directive: DNR. Review of the interdisciplinary progress notes from both EMR (Electronic Medical Record) systems revealed there was no documentation that the attending physician had a discussion directly with R2's legal guardian within 14 days of the signing of the DNR form on [DATE], or the order change from full code to DNR on [DATE]. There was no documentation from social services available in either EMR system. On [DATE] at 9:41 AM, the Director of Nursing (DON) was queried about R2's advance directive status of DNR and who was legally authorized to sign given the guardianship letter available for review was expired. The DON reported usually social work or admissions handles that. When asked about the discrepancy with full code and DNR, the DON reported she was unsure but would follow up. On [DATE] at 9:55 AM, the DON and MDS Nurse reported R2's guardianship had been approved for an extension on [DATE] and further reported there had been a delay due to COVID-19. When asked if there was any further documentation to support the requirements for a resident with a legal guardian and designation of DNR status, the DON reported she would follow up. The DON was asked to provide a facility policy for Advance Directives. There was no further documentation provided by the end of the survey.
F 0580 **Level of harm** - Minimal harm or potential for 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 635. Based on observation, interview and record review, the facility failed to follow up and notify the resident's attending physician of recommendations from an orthopedic surgeon for one (R#6) and notify the physician of skin wounds upon admission for one (R#124) of 17 residents reviewed for change in condition, resulting in the lack of review by the attending physician of the orthopedic surgeon's recommendations, which included lack of follow up for the resident with rheumatology or any documented coordination of care to proceed with the recommendation for surgery and resulting in a delay to implement a wound order consultation and wound treatment . Findings include: Resident #6 On 9/21/20 at 2:28 pm, an observation was made of R#6 standing by their bed in their room. When asked if they had any issues or concerns the resident stated in part .I have swelling at the knees and wrists .I have arthritis .I usually use a splint on this arm (pointing to the right arm) . A review of the clinical record revealed the following: R#6 initial admission into the facility was 9/26/18 with [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 15 (indicating intact cognition) and required physical help for bathing and setup for meals. An Orthopedic Surgery Consultation Note dated 3/29/2020, documented in part .Evaluated for R (right) hand pain with thumb MCP (metacarpophalangeal) volar dislocation noted on x-ray at the request of (doctor name redacted) who is providing her medical care .Pt (patient) notes having long-standing diffuse hand pain related to arthritis .She is right-hand dominant. An attempt at closed reduction at bedside was made 3/27 with thumb spica splint placed at that time. The joint was noted to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) feel unstable at that time and subsequent x-ray imaging revealed sustained dislocation .decreased strength throughout hand and wrist .R hand x-ray (3/27/2020) .sustained dislocation of the thumb MCP joint .Recommend outpatient R thumb MCP open vs closed reduction with arthrodesis given unstable MCP dislocation in combination with [MEDICAL CONDITION] arthropathy. Will defer to later date given pt relatively asymptomatic and current medical situation in era of COVID-19 and national state of emergency .discussed risks/benefits/alternatives with pt including functional deficits with and without surgical intervention .Will need cardiac clearance prior to surgical procedure .Recommend follow up with rheumatology . The clinical chart was reviewed and no documentation was found from the attending physician noting that they had reviewed the Orthopedic Surgery Consultation, no follow up with Rheumatology was found and no documentation of a plan of care for the surgery that was recommended. On 9/23/20 at 3:40 pm, the Director of Nursing (DON) was queried on if the attending physician reviewed the Orthopedic surgery consultation, if the resident followed up with Rheumatology and if the Interdisciplinary team (IDT) discussed the recommended surgery. The DON replied, normally a copy of the consultation would be put in the doctor's box and they will write on it once they have reviewed it. The DON requested time to look into the questions asked. On 9/24/20 at 9:23 am, the DON handed the surveyor their cellphone to speak with the Resident #6's attending physician. Resident #6's attending physician was queried if they reviewed the Orthopedic consultation from March 2020 (the recommendations were read to Resident #6's attending physician by the surveyor). Resident #6's attending physician stated in part .I never saw that consult note .They never discussed with me the recommendation for surgery, or the consult, or I would have done it and I would have remembered it too . At the conclusion of the phone call, the DON was asked again on why the facility didn't ensure that Resident #6's attending physician reviewed the consultation, why there was no documentation of the surgery being discussed with the IDT team and why the resident didn't follow up with rheumatology. The DON did not provide any additional information by the end of survey. A facility policy titled Provision of Medical Services with a revision date of 9/24/20, that documented in part .Consultative services will be made available from community-based consultants or from a local hospital or medical center .The medical director, administrator, and DON will collaborate to identify the scope of medical services in the facility .The medical director will help the facility identify and maintain a list of qualified consultants and specialists in various areas, such as podiatry, general surgery .who are willing to help provide on-site or community-based consultative care .The attending physician will be expected to oversee a relevant medical plan of care for each resident/patient .The attending physician will evaluate each resident/patient's progress and responses to treatment and will help assess the pertinence of ongoing interventions . Resident #124 A complaint was submitted to the State Agency regarding wound treatments not being completed for R#124's wounds while inpatient at the facility. An onsite survey was conducted to look into the complainant's allegation. R#124 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 13 (indicating intact cognition) and required assistance from staff for all activities of daily living. The clinical reviewed was reviewed and revealed the following: A Clinical Admission Evaluation dated 10/26/19 at 8:38 am, documented in part .Scrotum wound open to air .Resident has 1 open areas <sic> on his right foot, One open area on right ankle, and one open area on left ankle. Skin burn that has healed on bilateral leg . Further review of the clinical record revealed no documentation of the physician being notified of the wounds, an order for [REDACTED]. Change daily- Implemented 3 days after admission 10/28/19 at 1700 (5:00 pm), Wound care BLE extremities - Cleanse with normal saline, then apply opticell, Unnaboot (special dressing inelastic gauze that becomes rigid when it dries), coban (a layer wrap system). Change weekly one time a day every 7 day(s)- Implemented 3 days after admission. Discontinued on 10/29/19. 10/29/19 at 1900 (7:00 pm), Wound care BLE extremities- Cleanse with normal saline, then apply opticell, Unnaboot, coban. Change weekly every night shift every 7 days. A physician progress notes [REDACTED].The patient is seen and examined. He is very concerned regarding his wounds. They are to be treated today .There is an ulceration at the right medial ankle area. He has an ulcer reported under his scrotum and a photograph is noted. The patient has severe stasis [MEDICAL CONDITION] in the lower extremities .Wound care has been ordered . The Director of Nursing was asked to provide the photograph of R#124 scrotum, the DON replied We don't have a photograph of it. A wound care progress note dated 11/1/19 documented in part, .Wound #1 Scrotum/penis is a surgical wound and has received a status of Not Healed. Initial wound encounter measurements are 2cm (centimeters) length x 4cm width x 0.4cm depth, with an area of sq (square) cm and volume of 3.2 cubic cm. There is a moderate amount of sero-saguineous (a mixture of blood and fluid) noted which has no odor .10% yellow necrotic tissue .Wound #2 Right, Medial Ankle is a Venous Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 1cm length x 0.8cm width x 0.2cm depth, with an area of 0.8 sq cm and a volume of 0.16 cubic cm .Wound #3 Right, Lateral Lower Leg is a Venous Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2cm length x 0.5cm width x 0.2 cm depth, with an area of 1 sq cm and a volume of 0.2 cubic cm. There is a moderate amount of sero-sanguineous drainage noted .Treatment Recommendations- Santyl (wound ointment) + [MEDICATION NAME] AG (antimicrobial wound dressing) Q2D (every two days) and PRN (as needed)- Scrotum, Unna boot (with compression) Q3D (every three days) and PRN (as needed) - RLE (right lower extremity)- with coband . The Santyl + [MEDICATION NAME] AG Q2D and PRN and Unna boot with compression orders Q3D was never implemented as recommended by the wound care practitioner. On 9/28/20 at 10:50 am, the DON provided the resident care plans. All care plans were reviewed and there was no care plan found for the care of the resident's wounds. On 9/28/20 at 11:18 am, the DON was queried on the facility's protocol if a resident is admitted with wounds and stated in part .we continue the hospital treatments. We would call (the resident's physician) and get orders and put in a wound consult the day of admission . When asked why the resident wound consult and treatment was delayed for 3 days after admission, the DON did not offer any further explanation. A facility policy titled Pressure Ulcers/Skin Breakdown revised 9/28/20 documented in part .the physician and staff will examine the skin of a new admission for ulceration or indications of a Stage I pressure area that has not yet ulcerated at the surface. The physician will help the staff define the type (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of an ulceration .The physician will authorize pertinent orders related to wound treatments .The physician will help identify medical interventions related to wound management .The physician will help the staff review and modify the care plan as appropriate .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** This citation pertains to intake #MI 441. Based on observation, interview and record review, the facility failed to maintain the room occupied by R2 and R12 in a sanitary manner, resulting in the potential for resident dissatisfaction with their living conditions. Findings include: On 9/22/20 at approximately 1:00 PM and 9/23/20 at 8:47 AM, the room occupied by R2 and R12 was observed to have soiled floors and walls. The wall near the head of R2's bed had multiple large gouges. R12's privacy curtain was soiled with dark brown colored stains. R2 did not have any privacy curtain. Several large black flying insects were observed throughout the room. R2 was asked what happened to the wall and reported, I don't know but I know that's there. On 9/24/20 at 9:50 AM Dietary & Housekeeping Manager (Staff J) was asked about the facility's housekeeping services and cleaning schedules and reported Staff K was the only housekeeper currently and worked Monday through Friday from 8:30 AM to 5:00 PM. When asked what happened if there were concerns with housekeeping in the evening or on the weekends, Staff J reported, I come in on and off to alternate. When asked how that worked as Staff J was also the facility's Dietary Manager, Staff J declined to respond. Staff J was asked to accompany to observe the room occupied by R2 and R12 and requested to also bring Staff K as this staff was positioned just outside of R2 and R12's room. On 9/24/20 at 9:53 AM, Staff J and Staff K observed the room, confirmed the soiled walls, floors and privacy curtain and stated, Oh that's yucky. Staff J reported R2 currently did not have a privacy curtain as it was out for cleaning. When asked about the wall gouges, Staff J reported could be from the top of the bed hitting into the wall. When asked if there was a process for staff to report environmental concerns, Staff J reported, It's put on a concern form. Staff K reported working at the facility since November 2019. When asked about the cleaning schedule for resident rooms, Staff K provided a room schedule that identified the room occupied by R2 and R12 was due to be deep cleaned today. According to the schedule, the room should have been deep cleaned last on 9/9/20. Staff J and Staff K both reported there was no documentation that was maintained when the deep cleaning occurred except for the cleaning schedule. When asked if rooms were unable to be cleaned on a particular day, what was the process to ensure it was cleaned next, neither offered any further response. On 9/24/20 at approximately 10:15 AM, the Administrator was informed of the concerns as observed above and a policy was requested for

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F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) environmental care and any concern forms for environment/cleaning concerns. There were no concern forms provided by the end of the facility. A review of the facility's (Company Name) Healthcare Environmental Services Policy and Procedure Manual dated May 8, 2020 documented, in part: It is the policy of this facility to keep the environment clean and sanitary by following a routine schedule of cleaning and disinfecting .Report any needed repairs to the Maintenance Supervisor .Inspect and look for any signs of pests or infestations .Report immediately to the Supervisor (Housekeeping/Nurse) and Administrator .Check walls and doors. Clean windowsills, blinds. Look for stains and remove .Wipe clean of dirt and spots .Deep cleaning shall follow a rotating schedule of every 7 days. This means that every room must be deep cleaned at least once every 7 days (the schedule provided by Staff K was two times a month) .Replace curtain(s) with temporary curtains as needed) .
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 865. Based on interview and record review, the facility failed to ensure one resident (R120) was free from abuse by another resident (R5), resulting in multiple instances of R5 swearing at and throwing objects at R120 with intent to hit the resident to get R120 to shut up and stop yelling. Findings include: Review of the facility's investigation for the facility reported incident (FRI) identified an incident between R5 and R120 which occurred on 6/11/20 at 3:22 PM. Documentation dated 6/15/20 included, .On 06/11/20 the CENA (Certified Nursing Assistant) reported to the Administrator that the resident in (room occupied by R5) threw a cup of water & juice at resident (R120) wall and nursing immediately separated residents. Administrator interviewed both (R120 and R5). Resident (R5) stated aggressively that Yes I threw a cup of water & juice at his wall and I tried to hit him because I wanted him to shut up. Administrator questioned (R5) Did you hit your roommate? He stated No. BIMS (Brief Interview for Mental Status exam) score is 15 (intact cognition). next, the Administrator tried to interview resident (R120). The interview with (R120) was unsuccessful due to resident cognitive status. BIMS score is 0 Order to transfer Resident (R5) to ER (emergency room) for evaluation due to aggressive behavior and psychological evaluation .Conclusion: No physical harm, pain, or mental anguish. The incident was not substantiated. (signed 6/15/20 by the current Administrator). A review of R5's clinical record revealed an admission into the facility on [DATE] and discharge to the hospital on [DATE] with [DIAGNOSES REDACTED]. According to the discharge Minimum Data Set (MDS) assessment dated [DATE], R5 had intact cognition and had instances of physical and verbal behavioral symptoms directed towards others. A review of R120's clinical record revealed an admission into the facility on [DATE], discharged on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly MDS assessment dated [DATE], R120 had severely impaired cognition, had no mood or behavior concerns, and was dependent upon staff for all activities of daily living. Further review of the clinical records included the following progress notes: An entry on 6/11/20 at 3:22 PM documented BEHAVIOR NOTE: CNA (Certified Nursing Assistant) informed writer that resident (R5) had thrown items at roommate (R120) in bed (identifier redacted). Writer went in and ask resident if he had thrown items at resident. Resident stated, Yeah I did so what he keeps F-ing yelling. Writer informed him that he could not throw thing as it could result in injuries to either himself or roommate in bed (identifier redacted). Resident stated, Oh like a F-ing cup is going to hurt him. Writer repeated that he still could not throw anything at bed B. Resident then said, Well if he didn't F-ing yell then I wouldn't F-ing throw things at him. Resident then put on headphones and ignored writer. DON and Administrator notified. Residents separated Another entry on 6/11/20 at 6:27 AM documented, cna informed the nurse that while providing patient care to bed (R120) he (R5) was yelling out Shut the Fout of my room! Get him the F out of here! It smells in here! the nurse went into room (occupied by R120 and R5) and informed the pt (patient) that he could not talk to (R120) like that. that he (R5) cannot disrespect him (R120). the pt stated, well get him out of my room! the nurse informed him that he (R120) pays for the room just like him (R5). so please don't be disrespectful, the pt did say anything just cover his face with the cover. the nurse repeated statement uncovered his face, and said ok On 9/24/20 at 4:00 PM, an interview and record review was conducted with the Administrator who also acted as the facility's Abuse Coordinator. Upon review of the FRI, the Administrator reported the facility had sent R5 to the hospital following the incident as reported (6/11/20 at 3:22 PM). When asked if the facility had been aware of any other incidents, the Administrator denied being aware of any other incidents. Upon review of the progress note from 6/11/20 at 6:27 AM, the Administrator reported that she had not been aware of that and should have been. When queried about whether the Administrator had been notified of the incident at 6:27 am, the Administrator reported no and stated that was verbal abuse and should have been reported immediately. The Administrator was asked about the results of the investigation being unsubstantiated for abuse given R5 verbally acknowledged he had intent to hit R120, the Administrator reported that should have been substantiated. A review of the facility's Resident Abuse/Neglect policy dated Revision Date: 1/30/2019 documented in part: .Abuse is defined as willful infliction of injury .intimidation, or punishment with resulting physical harm, pain or mental anguish .It includes verbal abuse .physical abuse .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .
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 865. Based on interview and record review, the facility failed to report actual resident to resident abuse to the facility's Administrator (Abuse Coordinator) and/or the State Agency (SA) for two (R5 and R120) of seven residents reviewed for abuse, resulting in continued abuse due to lack of identifying and reporting an initial instance of resident to resident abuse, delayed investigation, and the SA not being aware of abuse allegations in a timely manner. Findings include: Review of the facility's investigation for the facility reported incident (FRI) identified an incident between R120 and R5 which occurred on 6/11/20 at 3:22 PM. Documentation dated 6/15/20 included, .On 06/11/20 the CENA (Certified Nursing Assistant) reported to the Administrator that the resident in (room occupied by R5) threw a cup of water & juice at resident (R120) wall and nursing immediately separated residents. Administrator interviewed both (R120 and R5). Resident (R5) stated aggressively that Yes I threw a cup of water & juice at his wall and I tried to hit him because I wanted him to shut up. Administrator questioned (R5) Did you hit your roommate? He stated No. BIMS (Brief Interview for Mental Status exam) score is 15 (intact cognition). next, the Administrator tried to interview resident (R120). The interview with (R120) was unsuccessful due to resident cognitive status. BIMS score is 0 Order to transfer Resident (R5) to ER (emergency room) for evaluation due to aggressive behavior and psychological evaluation .Conclusion: No physical harm, pain, or mental anguish. The incident was not substantiated. (signed 6/15/20 by the current Administrator). A review of R5's clinical record revealed an admission into the facility on [DATE] and discharge to the hospital on [DATE] with [DIAGNOSES REDACTED]. According to the discharge Minimum Data Set (MDS) assessment dated [DATE], R5 had intact cognition and had instances of physical and verbal behavioral symptoms directed towards others. A review of R120's clinical record revealed an admission into the facility on [DATE], discharged on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly MDS assessment dated [DATE], R120 had severely impaired cognition, had no mood or behavior concerns, and was dependent upon staff for all activities of daily living. Further review of the clinical records included the following progress notes: An entry on 6/11/20 at 3:22 PM documented BEHAVIOR NOTE: CNA (Certified Nursing Assistant) informed writer that resident (R5) had thrown items at roommate (R120) in bed (identifier redacted). Writer went in and ask resident if he had thrown items at resident. Resident stated, Yeah I did so what he keeps F-ing yelling. Writer informed him that he could not throw thing as it could result in injuries to either himself or roommate in bed (identifier redacted). Resident stated, Oh like a F-ing cup is going to hurt him. Writer repeated that he still could not throw anything at bed B. Resident then said, Well if he didn't F-ing yell then I wouldn't F-ing throw things at him. Resident then put on headphones and ignored writer. DON and Administrator notified. Residents separated Review of additional documentation revealed prior to this reported incident from 6/11/20 at 3:22 PM, the facility had knowledge of another incident on 6/11/20 at 6:27 AM which read, cna informed the nurse that while providing patient care to bed (R120) he (R5) was yelling out Shut the Fout of my room! Get him the F out of here! It smells in here! the nurse went into room (occupied by R120 and R5) and informed the pt (patient) that he could not talk to (R120) like that. that he (R5)

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) cannot disrespect him (R120). the pt stated, well get him out of my room! the nurse informed him that he (R120) pays for the room just like him (R5). so please don't be disrespectful, the pt did say anything just cover his face with the cover. the nurse repeated statement uncovered his face, and said ok On 9/24/20 at 4:00 PM, an interview and record review was conducted with the Administrator who also acted as the facility's Abuse Coordinator. Upon review of the FRI, the Administrator reported the facility had sent R5 to the hospital following the incident as reported (6/11/20 at 3:22 PM). When asked if the facility had been aware of any other incidents, the Administrator denied being aware of any other incidents. Upon review of the progress note from 6/11/20 at 6:27 AM, the Administrator reported that she had not been aware of that and should have been. The Administrator was asked about the results of the investigation being unsubstantiated for abuse given R5 verbally acknowledged he had intent to hit R120, the Administrator reported that should have been substantiated. When queried about whether the Administrator had been notified of the incident at 6:27 am, the Administrator reported no and stated that was verbal abuse and should have been reported immediately. On 9/28/20 at 9:26 AM, a phone interview was conducted with RN H. RN H reported working the midnight shift. When queried about the entry noted by RN H on 6/11/20 at 6:27 AM, RN H reported, I documented it and I did report during report to the oncoming shift. When asked what the facility's process was when abuse was identified or reported to a nurse, RN H reported, I'm trying to think if I told anyone else. I don't want to say if I did or not. When asked who would report abuse allegations to, RN H stated, My supervisor, the DON and if not available the Administrator. When asked what was done to protect R120 from further abuse from R5, RN H reported what was documented. A review of the facility's Resident Abuse/Neglect policy dated Revision Date: 1/30/2019 documented in part: .Any individual observing an incident or resident abuse, suspecting resident abuse, or receiving an allegation of resident abuse must immediately report such incident to the Administrator or Director of Nursing Services .If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident .Incidents involving alleged, suspected or actual abuse .shall be reported to the state immediately, but not more than 2 hours after forming the suspicion .
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 865. Based on interview and record review, the facility failed to identify, investigate, and protect a resident from further abuse for two (R5 and R120) of seven residents reviewed for abuse, resulting in continued abuse when R120 remained in the same room with R5 following an earlier instance of resident to resident abuse in which staff failed to recognize and report as abuse, and protect from further abuse that occurred later that day. This has the increased likelihood for continued and unidentified abuse situations to occur. Findings include: Review of the facility's investigation for the facility reported incident (FRI) identified an incident between R120 and R5 which occurred on 6/11/20 at 3:22 PM. Documentation dated 6/15/20 included, .On 06/11/20 the CENA (Certified Nursing Assistant) reported to the Administrator that the resident in (room occupied by R5) threw a cup of water & juice at resident (R120) wall and nursing immediately separated residents. Administrator interviewed both (R120 and R5). Resident (R5) stated aggressively that Yes I threw a cup of water & juice at his wall and I tried to hit him because I wanted him to shut up. Administrator questioned (R5) Did you hit your roommate? He stated No. BIMS (Brief Interview for Mental Status exam) score is 15 (intact cognition). next, the Administrator tried to interview resident (R120). The interview with (R120) was unsuccessful due to resident cognitive status. BIMS score is 0 Order to transfer Resident (R5) to ER (emergency room) for evaluation due to aggressive behavior and psychological evaluation .Conclusion: No physical harm, pain, or mental anguish. The incident was not substantiated. (signed 6/15/20 by the current Administrator). A review of R5's clinical record revealed an admission into the facility on [DATE] and discharge to the hospital on [DATE] with [DIAGNOSES REDACTED]. According to the discharge Minimum Data Set (MDS) assessment dated [DATE], R5 had intact cognition and had instances of physical and verbal behavioral symptoms directed towards others. A review of R120's clinical record revealed an admission into the facility on [DATE], discharged on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly MDS assessment dated [DATE], R120 had severely impaired cognition, had no mood or behavior concerns, and was dependent upon staff for all activities of daily living. Further review of the clinical records included the following progress notes: An entry on 6/11/20 at 3:22 PM documented BEHAVIOR NOTE: CNA (Certified Nursing Assistant) informed writer that resident (R5) had thrown items at roommate (R120) in bed (identifier redacted). Writer went in and ask resident if he had thrown items at resident. Resident stated, Yeah I did so what he keeps F-ing yelling. Writer informed him that he could not throw thing as it could result in injuries to either himself or roommate in bed (identifier redacted). Resident stated, Oh like a F-ing cup is going to hurt him. Writer repeated that he still could not throw anything at bed B. Resident then said, Well if he didn't F-ing yell then I wouldn't F-ing throw things at him. Resident then put on headphones and ignored writer. DON and Administrator notified. Residents separated Review of additional documentation revealed prior to this reported incident from 6/11/20 at 3:22 PM, the facility had knowledge of another incident on 6/11/20 at 6:27 AM which read, cna informed the nurse that while providing patient care to bed (R120) he (R5) was yelling out Shut the Fout of my room! Get him the F out of here! It smells in here! the nurse went into room (occupied by R120 and R5) and informed the pt (patient) that he could not talk to (R120) like that. that he (R5) cannot disrespect him (R120). the pt stated, well get him out of my room! the nurse informed him that he (R120) pays for the room just like him (R5). so please don't be disrespectful, the pt did say anything just cover his face with the cover. the nurse repeated statement uncovered his face, and said ok On 9/24/20 at 4:00 PM, an interview and record review was conducted with the Administrator who also acted as the facility's Abuse Coordinator. Upon review of the FRI, the Administrator reported the facility had sent R5 to the hospital following the incident as reported (6/11/20 at 3:22 PM). When asked if the facility had been aware of any other incidents, the Administrator denied being aware of any other incidents. Upon review of the progress note from 6/11/20 at 6:27 AM, the Administrator reported that she had not been aware of that and should have been. The Administrator was queried about whether she had been notified of the incident at 6:27 am and the Administrator reported no and stated that was verbal abuse and should have been reported immediately. When queried what should have been done to protect the resident from continued abuse, the Administrator reported had the facility been aware earlier, R120 may not have been subjected to another instance of abuse. The Administrator acknowledged there was no investigation into the incident on 6/11/20 at 6:27 AM and reported one should have been reported and initiated immediately. On 9/28/20 at 9:26 AM, a phone interview was conducted with RN H. RN H reported working the midnight shift. When queried about the entry noted by RN H on 6/11/20 at 6:27 AM, RN H reported, I documented it and I did report during report to the oncoming shift. When asked what the facility's process was when abuse was identified or reported to a nurse, RN H reported, I'm trying to think if I told anyone else. I don't want to say if I did or not. When asked who would report abuse allegations to, RN H stated, My supervisor, the DON and if not available the Administrator. When asked what was done to protect R120 from further abuse from R5, RN H reported what was documented. A review of the facility's undated Protection of Residents During Abuse Investigations policy provided documented in part: .During abuse investigations, residents will be protected from harm by the following measures .If the alleged abuse involves another resident, the accused resident's representative and Attending Physician will be informed of the alleged abuse incident and that there may be restrictions on the accused resident's ability to visit other resident rooms unattended . A review of the facility's Resident Abuse/Neglect policy dated Revision Date: 1/30/2019 documented in part: .Any individual observing an incident or resident abuse, suspecting resident abuse, or receiving an allegation of resident abuse must immediately report such incident to the Administrator or Director of Nursing Services .If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident .Should an actual, suspected or alleged incident resident abuse .be reported, the Administrator, or his/her designee, will initiate investigation of, or appoint a member of the management team to investigate the incident .
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify, in writing, the reason for residents acute transfer (from the facility to the hospital) to a representative of the State Long Term Care Ombudsman for five (R#s: 5, 9, 19, 70, and 122) of five residents reviewed for hospital transfers/discharges, resulting in notifications required for transfer to ensure resident rights were maintained. Findings Include: Resident #5: Review of the clinical record revealed R#5 was

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the discharge Minimum Data Set (MDS) assessment dated [DATE], R#5 was modified independent with cognitive skills for daily decision making, had physical and verbal behavioral symptoms directed towards others, and required extensive assistance with transfers. R#5 was discharged to the hospital on [DATE] and did not return. Resident #9: Review of clinical record revealed R#9 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the quarterly MDS assessment dated [DATE] revealed R#9 had a BIMS score of 5 out of 15 which indicated severely impaired cognition and required extensive assistance with one-person physical assist for most activities of daily living (ADL) care. Per facility Progress Notes dated 6/24/20 at 5:01 p.m., R#9 was assessed by the physician; lab results received and wbc (white blood count) is elevated. resident is complaining of pain all over, moaning and rocking. Prn (as needed) pain med (medication) given with little effect. new orders received to send resident to ER (emergency room) to evaluate elevated wbc and pain. On 7/6/20 at 4:00 p.m., an admission progress note revealed R#9 arrived via W/C (wheelchair) to facility accompanied by one transporter .Patient alert et <sic> oriented to self and place, some confusion noted .admitted to facility with left foot infection. Wound vac awaiting to be delivered . On 7/15/20 at 4:06 p.m., a nursing progress note revealed R#9 received lab work reviewed by the attending physician, resident pale, moaning, states he doesn't feel good. lab work showed wbc (white blood cell) increased to 22. orders received to send resident to ER for eval and treatment .hospitalized ,[DATE] - 7/27/2020 for DKA (Diabetic Ketoacidosis) . Resident #19: Review of clinical record revealed R#19 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The 30-day readmission MDS assessment dated [DATE] revealed R#19 had a BIMS score of 15 out of 15 which indicated intact cognition and required extensive assistance with one to two-person physical assist for ADLs. A progress note dated 7/5/20 revealed R#19 returned from ER .UA (urine analysis) positive for UTI (urinary tract infection) . Resident #70: Review of the clinical record revealed R#70 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the 5-Day MDS assessment dated [DATE] revealed R#70 was moderately impaired and required extensive assistance with one to two-person physical assistance with most ADLs. Review of the facility's Investigation Summary revealed R#70 was sent to hospital on [DATE] due to continued behavior symptoms .Resident was transferred to hospital for evaluation of [MEDICAL CONDITION] (Post Traumati[DIAGNOSES REDACTED] Disorder) symptoms. Resident #122: Review of the clinical record revealed R#122 was originally admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Further review of the 14-Day MDS assessment dated [DATE] revealed R#122 had severely impaired cognition and required extensive assistance with one-person physical assist for most ADL care. The progress note dated 1/28/2020 revealed R#122 was transferred to the hospital unresponsive . BP (blood pressure) was 88/43 with the machine. Unable to obtain a manual BP. Pulse Ox (oximetry) registered between 67%-74% on room air. Heart Rate was 48. Respirations were 28 with rhonchi (rattling lung sounds) noted. Accu check (glucose monitoring use for diabetes) was 141. Breathing treatment was given. D.O.N. (Director of Nursing), writer and nurse from the other side were at the bedside. NRB (non-rebreather mask) applied. 911 called. ER (emergency room) and doctor notified. On 9/28/20 at 8:45 a.m., the Administrator was asked who was responsible for providing the monthly transfer/discharge hospital written report to the representative of the State Long Term Care Ombudsman. The Administrator stated, I'll have to check. On 9/28/20 at 9:10 a.m., the Administrator returned with a report for January 2020, and stated she had contacted former Social Services Tech 'L' (whose last day was 9/18/20), and asked if there were any reports for the months of February thru August 2020. The Administrator did not have an explanation. On 9/28/20 at 9:30 a.m., a call was placed to Social Services Tech 'L' to ask if there were any resident hospitalization reports sent to the Ombudsman for February thru August 2020. There was no answer and a message was left on the voicemail. Social Services Tech 'L; did not return the call by the end of the survey. A review of the facility's policy titled Transfer or Discharge - Immediate Preparation revised 9/28/20 revealed the following: Policy Interpretation and Implementation .3. The Social Worker will be responsible for: a. In the event that the transfer/discharge is facility initiated, notification of the ombudsman of the transfer/discharge. b. the Social Worker will send the Ombudsman a list of all discharges monthly or more frequently if requested in writing by the Ombudsman .5. In the event that the resident is transferred or discharged unexpectedly on an off shift or weekend, nursing will complete and provide the resident/guardian/ombudsman with the required notices.
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** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for one resident (R#17) of 17 residents reviewed for comprehensive care plans, resulting in a lack of coordination of care and inconsistent application of ted hose ([MEDICAL CONDITION] disease) hose (elastic stockings that compress the veins in the lower limbs). Findings Include: On 9/22/20 at 9:47 a.m., R#17 was observed in bed. Their legs, ankles and feet were [MEDICAL CONDITION]. When asked questions about their care at the facility, R#17 stated, My legs are swelling like crazy. I wish the swelling would go down in my legs. They were wrapping them. I don't know why they stopped. I told the nurse, she said, 'She don't know why they stopped wrapping them.' Review of the clinical record revealed R#17 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#17 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. A physician's orders [REDACTED].#17's care plans revised on 8/20/20 did not reveal a plan of care for use of Ted Hose. On 9/22/20 at 2:35 p.m., during an interview, the Director of Nursing (DON) was asked if R#17 had an order to apply Ted Hose, should there be a care plan? The DON stated, Yes there should be a care plan. I'll talk with MDS (Coordinator who was located at another site) to see . On 9/22/20 at 3:30 p.m., during the Confidential Group meeting, R#17 was observed wearing non-skid socks on their swollen feet. R#17 was not wearing Ted Hose as prescribed by the physician. On 9/23/20 at 12:10 p.m., R#17 was observed in bed with swollen legs, ankles, and feet. R#17 was not wearing Ted hose. When asked if they were supposed to have Ted Hose on their legs, R#17 stated, Yes. When asked the last time they wore Ted Hose on their legs, R#17 stated, I don't know. On 9/23/20 at 3:20 p.m., the Administrator reported there was a care plan in the electronic clinical record for R#17's Ted Hose. A review of the care plan revealed it was initiated on 9/23/20. Review of the facility's policy titled Care Plans - Comprehensive .Assessment & Care Planning revised 9/24/20 read as follows: Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident .Policy Interpretation and Implementation .2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS .Interdisciplinary Process: 6 .No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS) .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure care plans were revised related to nutritional needs and fall incidents for one (R2) of 17 residents reviewed for care plans, resulting in the increased potential for unmet needs and lack of coordinated care. Findings include: A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition, required supervision with set up for eating, received a mechanically altered diet, had a weight of 155 with no weight changes (either increase or decrease), and had multiple falls. A review of the interdisciplinary progress notes revealed: On 9/3/20 at 3:56 PM, an entry by Nurse E read, Pt (patient) observed having difficulty while eating. OT (Occupational Therapy) notified. On 9/4/20 at 2:04 PM, an entry by Nurse V read, Pt observed having difficulty while eating. OT notified. On 9/22/20 at approximately 1:00 PM, R2 was observed seated in a Geri chair recliner with an overbed tray table in front of the resident. R2 was very thin and had long fingernails with dark debris underneath the nail tips. On 9/23/20 at approximately 10:30 AM, an interview was conducted with RD C. When queried about R2's weight and nutritional status and whether there were any reported concerns for R2's such as decreased oral intake, difficulty eating, or ability to feed self, RD C denied being aware of any recent concerns or

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) changes. On 9/23/20 at approximately 10:50 AM, an observation of R2's weight with RD C revealed a current weight (taken while R2 stood on the scale) as 133.4 pounds. The last documented weight for R2 was on 9/17/20 as 143 pounds (a severe weight loss of 6.71% in six days; facility policy noted 5% in one month was considered severe). On 9/23/20 at 11:04 AM, RD C was requested to provide any additional documentation regarding R2's weights including any assessments and care plans as the facility had previously used another Electronic Medical Records (EMR) system prior to June 2020. On 9/23/20 at 11:25 AM, RD C confirmed the last documented nutritional assessment was completed on 7/23/20. A review of R2's nutritional documentation provided by RD C included a nutrition care plan which had been initiated 6/10/20, with no further revisions/interventions implemented. This care plan documented, in part: Problem Start Date: 06/10/2020 .Resident has potential alteration in nutritional status R/T (related to) PMH (past medical history) of: DYSPHAGIA; [MEDICAL CONDITION]; IS ON MECHANICALLY ALTERED DIET of Puree with nectar thick liquids. New baseline weight is 140#. Res (resident) is able to stand. On 9/23/20 at 12:22 PM, RD C was asked about the lack of revised interventions since 6/10/20 and nutritional assessment following the 7/23/20 assessment, RD C provided no response. When asked if there was any physician involvement or notification regarding any unintended weight loss, difficulty eating, or nutritional concerns for R2, RD C stated, No. I'm only here one time a week. We do (review) at risk weekly meetings, the DON (Director of Nursing) will identify and notify the physician. A review of R2's fall documentation provided by the facility identified R2 had 14 fall incidents since admission on 1/16/20. Further review of 14 fall incidents on 1/20, 1/22, 1/27, 1/28, 2/3, 2/18 4/10, 4/16, 6/2, 7/6, 7/26, 9/8 (fall 1), 9/8 (fall 2) and 9/11. A review of R2's current fall care plan that was available for review documented, in part: Problem Start Date: 06/10/2020 .Resident is at risk for falling R/T (related to): Dementia; cognitive limits; Hx (history of) frequent falls; poor safety awareness; impulsive with transfers; [MEDICAL CONDITION]; poor awareness of body position; medication side effects; (name of R2) had falls at previous facility per family; Updated fall risk at 21. Review of the interventions revealed there was no updated interventions following the two falls on 9/8/20. Although access was given to the previous EMR system prior to June 2020, care plans were restricted. Unable to identify what interventions had been reviewed and/or revised for the fall incidents on 1/20, 1/22, 1/27, 1/28, 2/3, 2/18, 4/10, and 4/16. On 9/24/20 at 11:24 AM, when queried about who was responsible to ensure care plans were revised upon changes in resident's status, or upon review/revision of current interventions, the DON reported usually MDS and/or each department. A review of the Care Plans - Comprehensive policy dated Reviewed 9/24/20 documented, in part: .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans . A Nutrition (Impaired)/Unplanned Weight Loss policy dated Reviewed 9/23/2020 documented, in part: .The Physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include .Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals .
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #s MI 441 and MI 462. Based on observation, interview and record review, the facility failed to provide appropriate nail care for one (R2) of three residents reviewed for activities of daily living (ADLs), resulting in unmet nail care for a dependent resident, the increased potential for infection if skin becomes scratched from the unkempt nails and embarrassment from unmet hygiene needs. Findings include: A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition, required supervision with set up for eating, received a mechanically altered diet, and required extensive assist of one person for all ADLs including personal hygiene and bathing. On 9/22/20 at approximately 1:00 PM, R2 was observed seated in a Geri chair recliner with an overbed tray table in front of the resident. R2 was very thin and had long fingernails with dark debris underneath the nail tips. R2 repeatedly attempted to scoop up orange liquid that had spilled all over the food tray with a spoon and fingers. On 9/23/20 at 8:47 AM, R2 was observed eating breakfast and the fingernails on both hands remained long in length with dark debris underneath the nail tips. On 9/23/20 at approximately 8:50 AM, the Certified Nursing Assistant (CNA) B assigned to R2 was asked about the long and dirty nails and stated, He only lets certain aides do it. They're done when he gets a shower. When asked if nail care had been offered or refused today, CNA B reported nail care had not been provided today. When asked what happens if residents refused, CNA B reported would let the nurse know since there is no process to document in their current CNA electronic charting for the residents. On 9/25/20 at 9:25 AM, the Director of Nursing (DON) was queried about R2's showers and nail care. The DON reported the current process for shower documentation was to complete the shower sheets in the shower binder kept at the nursing station. A review of the shower binder revealed multiple missing documentation of showers and the documentation that was available had multiple blank/incomplete entries for nail care as prompted to fill-in on the forms. The DON was queried about the incomplete documentation and offered no further response. When asked about when nail care should be completed, the DON reported, Daily, staff should be looking. When asked if there were any documented refusals, the DON reported, CNAs don't document refusals, they should let the nurse know and nurse would note on shower sheet or in progress note. The DON was informed that the documentation that was available for review revealed no refusal of care. On 9/24/20 at 9:43 AM, an interview was conducted with CNA O who was assigned to R2. When asked about the long, dirty nails, CNA O stated, Oh yeah. Should be done today, it's actually his shower day. When asked if CNA O was aware of any refusal of nail care, or if nail care had to wait until shower days, CNA O reported, No and could be done regularly, anytime. A review of R2's ADL care plan initiated 6/10/20 documented Resident has a self-care deficit R/T (related to): Activity Intolerance, Dementia, Mobility Limits . Interventions included: Nail care with showers and prn (as needed) Nursing Every Shift; Day 07:00 AM - 07:00 PM, Day 07:00 PM - 07:00 AM. A review of the facility's Activities of Daily Living (ADLs) policy dated 9/24/20 documented, in part: .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .established nutritional and weight goals .
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #MI 635 and #MI 441. This citation has two deficient practice statements. Deficient Practice Statement #1: Based on interview and record review, the facility failed to reassess, monitor, treat in a timely and appropriate manner a resident with low blood pressure level, for one (R#122) of two residents reviewed for change of condition, resulting in the resident becoming non-responsive, a transfer to the hospital emergency department, ICU (Intensive Care Unit) admission, and placed on a ventilator. Findings Include: A complaint was filed with the State Agency (SA) on 1/28/20 that alleged the facility failed to assess and monitor the resident for respiratory distress resulting in ICU admission. The complaint further read, On 1/28/20 the facility was going to discharge the resident, but the daughter said the resident was not well enough to be discharged . The resident had a mental status change and was having difficulty breathing the daughter told the staff to call 911. The resident was admitted to local hospital (Name Redacted) 'Y' and sent to the ICU on a ventilator. Review of the clinical record revealed R#122 was originally admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Further review of the 14-Day Minimum Data Set (MDS) assessment dated [DATE] revealed R#122 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicting severely impaired cognition and required extensive assistance with one-person physical assist for most ADL care. R#122's care plan revealed the following: Focus: (R#122) is at risk for cardiac distress R/T (related to) DX (Diagnosis) of HTN,[MEDICAL CONDITIONS] . Support/Task: Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic [MEDICAL CONDITION] and increased heart rate ([MEDICAL CONDITION] and effectiveness . Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, [MEDICAL CONDITION] activity, difficulty breathing (Dyspnea). Vital signs as ordered. Progress Note dated 1/28/2020 at 08:35 (8:35 am) . Skilled Evaluation . Vitals: Temperature: T 98.4 - 1/28/2020

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) 08:35 Route: Oral Blood Pressure: BP 98/56 (Normal is 120/less than 80), - 1/28/2020 08:36 Position: Other Pulse: P 72 - 1/28/2020 08:36 Pulse Type: Regular . Respiration: R 18 - 1/28/2020 08:36 O2 sats: O2 94 % - 1/28/2020 08:36 Method: Room Air Blood Glucose: (Blank) Weight: W 63.0 lb. - 1/16/2020 19:06 Scale Indicators of pain: None. Progress note dated 1/28/2020 at 09:39 (9:39 am) Orders - Administration Note Text: flush peg tube 100 cc (cubic centimeter) water every shift to maintain patency every shift Refused x 3. There were no progress notes or documentation of R#122's condition after 9:39 a.m. until 5:06 p.m. (approximately 8 hours) before R#122 was found unresponsive by the nurse. The facility failed to identify R#122's declining change of condition before the family identified it first. Progress note dated 1/28/2020 at 17:06 (5:06 pm), Note Text: Daughter was here to pick up the resident and the CNA (Certified Nursing Assistant) went into the room to assist the resident to put on her coat. Daughter was agitated r/t (related to) discharge. Per CNA the daughter was on the phone upset about being discharge. Resident was alert and verbal. Writer and the nurse from the other hall were notified by the daughter that the resident was now breathing like crap. Nurse from the other hall went into the room. Writer also went into the room and observed the resident unresponsive . BP (Blood Pressure) was 88/43 with the machine. Unable to obtain a manual BP. Pulse Ox (Oximeter) registered between 67%-74% on room air. Heart Rate was 48. Respirations were 28 with rhonchi (rattling lung sounds) noted. Accu check (glucose monitoring use for diabetes) was 141. Breathing treatment was given. D.O.N. (Director of Nursing), writer and nurse from the other side were at the bedside. NRB (non-rebreather mask) applied. 911 called. ER (emergency room) and doctor notified. Review of the local hospital (Named Redacted) 'Y' medical records revealed the following: Date of Admit: 01/28/2020 18:24 (6:24 p.m.) thru Date of Service: 02/10/2020 (13 days) Reason for hospitalization : Dyspnea Last Set of Vitals: BP: 93/52 - 2/10/20, Pulse: 93 - 2/4/20, . O2 Sat: 59.0% (100%) (Ventilator) - 2/8/20, Heart Rate: 65 - 2/10/20 Hospital Course: .(Identity Redacted) (R#122) who presents to local hospital (Name Redacted) 'Y' ED from facility (Name Redacted) for [MEDICAL CONDITION] (absence of enough oxygen in the tissues to sustain bodily functions) and increased work of breathing. Patient was found to be saturating in the low 60s which did not improve with non-rebreather breathing treatments <sic> Per nursing report, there was concern patient aspirating earlier during the day . In the ER patient was placed on [MEDICAL CONDITION] with slight improvement. She was also found to be hypotensive with systolic 80s . Her mentation continued to decline and there was concern for inability to protect her airway; subsequently patient was intubated . She was .transferred to the ICU for further management . admitting [DIAGNOSES REDACTED].[MEDICAL CONDITION] Disorder .Esophagitis and gastritis . Essential Hypertension, [MEDICAL CONDITION] . On 9/28/20 at 1:50 p.m., an interview was conducted with the DON regarding R#122's low blood pressure. The DON was asked what was the facility's protocol when a resident is not at their baseline regarding vitals? The DON stated, She (R#122) ran low. She was really little. The nurse would not have taken vitals because that was her (R#122) norm. I think it was her sugar that dropped. The doctor was here. I think he saw her .She was going to be discharged . There was no documentation in the clinical record that R#122 was seen by the physician after their decreased blood pressure level. Blood Pressure Vitals from 1/11/20 (readmission) to 1/28/20 (discharge) revealed the following: 1/28/2020 16:03 88 / 43 mmHg Other (Manual) 1/28/2020 08:36 98 / 56 mmHg Other (Manual) 1/27/2020 12:40 105 / 70 mmHg (Manual) 1/27/2020 03:30 133 / 82 mmHg Sitting r/arm (Manual) 1/26/2020 16:02 121 / 53 mmHg (Manual) 1/26/2020 03:30 118 / 73 mmHg Lying l/arm (Manual) 1/25/2020 12:13 105 / 73 mmHg (Manual) 1/24/2020 14:13 106 / 55 mmHg (Manual) 1/18/2020 13:46 101 / 60 mmHg Sitting r/arm (Manual) 1/14/2020 08:01 133 / 70 mmHg (Manual) 1/13/2020 11:35 105 / 67 mmHg (Manual) 1/12/2020 10:44 153 / 98 mmHg (Manual) 1/12/2020 02:19 120 / 87 mmHg Lying l/arm (Manual) 1/11/2020 13:06 112 / 59 mmHg (Manual) 1/11/2020 03:47 127 / 73 mmHg Lying l/arm (Manual) When queried if former Nurse 'Z' should have reassessed (within 8 hours), documented, and/or reported (R#122's) abnormal vitals on 1/28/20) to the Unit Manager/Charge Nurse, DON or called the physician, the DON stated, They (Nurse 'Z') should have reassessed (R#122) if (their) blood pressure was low. A review of the facility's policy titled Change in a Resident's Condition or Status - Protocols and Standards revised 9/28/20 read in part as follows: Policy Statement: Facility (Name Redacted) will promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .Policy Interpretation and Implementation: 1. The Nurse Supervisor/Charge nurse will notify the resident's Attending Physician or On-Call Physician when there has been .d. A significant change in the resident's physical/emotional/mental condition .f. Refusal of treatment or medications (i.e., two (2) or more consecutive times); g. a need to transfer the resident to a hospital/treatment center .2. A significant change of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions .3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when .b. There is a significant change in the resident's physical, mental, or psychosocial status .6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . Deficient Practice Statement #2: Based on observation, interview and record review, the facility failed to ensure that ted ([MEDICAL CONDITION] disease) hose (elastic stockings that compress the veins in the lower limbs) were consistently applied per physician's order for one (R#17) and provide skin/wound treatments per physician orders for one (R#121) resident of two resident reviewed for physician orders, resulting in continuous swelling and the potential for blood clots to form for R#17 and the potential for delayed surgical healing, worsening of skin conditions and infection for R#121. Finding Include: R#17 Review of the clinical record revealed R#17 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE] R#17 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition and was independent with no assistance from staff for activities of daily living. On 9/22/20 at 9:47 a.m., R#17 was observed in bed. Their legs, ankles and feet were [MEDICAL CONDITION]. When asked questions about their care at the facility, R#17 stated, My legs are swelling like crazy. I wish the swelling would go down in my legs. They were wrapping them. I don't know why they stopped. I told the nurse, she said, 'She don't know why they stopped wrapping them. A physician's order started 7/16/20 revealed the following: TED hose to be applied every morning and dc'd (discontinued) every evening Once A Day 06:00 AM On 9/22/20 at 3:30 p.m., during the Confidential Group meeting, R#17 was not wearing Ted Hose as prescribed by the physician, but instead, R#17 was wearing non-skid socks on their swollen feet. On 9/23/20 at 12:10 p.m., Resident was observed in bed with [MEDICAL CONDITION] (swollen with excessive accumulation of fluid) legs. When asked if they were supposed to have Ted Hose on their legs, R#17 stated, Yes. R#17 was observed without Ted Hose. When asked the last time they wore Ted Hose on their legs, R#17 stated, I don't know. On 9/23/20 at 3:30 p.m., during an interview, when asked how it was determined when to apply R#17's Ted Hose, Certified Nursing Assistant (CNA) 'I' stated, If it's in their care, I just make sure they are on. The nurses will let us know. On 9/23/20 at 3:35 p.m., Registered Nurse (RN) 'F', was asked who was responsible for the application of R#17's Ted Hose. RN 'F' stated, It's on the MAR and the nurses just have to make sure the CNAs apply them. Whether delegate or just do it themselves. On 9/23/20 at 3:45 p.m., an observation of R#17's legs was made along with CNA 'O'. R#17 was not wearing Ted Hose. R#17 was queried as to why they were not wearing Ted Hose. R#17 stated, I don't know. On 9/23/20 at 3:50 p.m., RN, 'F' was queried why R#17 was not wearing Ted Hose. RN 'F' explained the midnight shift was supposed to put them on. When asked if the midnight shift did not apply R#17's Ted Hose, who was supposed to put them on? At that time, RN 'F' was asked when they went into R#17's room to administer medication, if they checked to see if R#17 was wearing their Ted Hose, RN stated, No . On 9/23/20 at 4:00 p.m., an interview was conducted with the DON regarding the application of R#17's Ted Hose. The DON stated, They (nurses and CNAs) should put them on. It was on the Medication Administration Record (MAR) and not the Treatment Administration Record (TAR) for the CNAs to see it . Review of the MAR for September 2020 did not reveal an order for [REDACTED].#17's Ted Hose. On 9/24/20 at 2:55 p.m., R#17 was in bed with bilateral ace bandage wraps. R#17 stated, They wrapped them since they don't have the stockings. Review of the facility's policy titled Applying anti-Emboli Stockings (Ted Hose) revised 8/5/2020 read in part as follows: Purpose .to improve venous return to the heart, to improve arterial circulation to the feet, to minimize [MEDICAL CONDITION] to the legs and feet, and to prevent complications associated with [MEDICAL CONDITION] and [MEDICAL CONDITION] embolism. Preparation: 1. Verify that there is a physician's order for anti-emboli stockings .2. Review the resident's care plan to assess for any special needs .General Guidelines: 1. If possible, anti-emboli stockings should be applied in the morning, prior to the resident getting out of bed. 2. Remove the stockings every eight (8) hours and inspect the skin. Leave the stockings off for 30 minutes and then reapply, as ordered .Assessment: 1. Assess the lower extremities for: a. Posterior tibial and dorsalis pedis pules .b. Skin color, temperature and condition, skin irritation, and open areas; c. Presence of [MEDICAL CONDITION] .d. Pain or tenderness in the calf .Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that anti-emboli stockings were applied. 2. The stocking size and length .5. The schedule of removal and reapplication. 6. If the resident refused the

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	235703	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR NURSING & REHAB CENTER LLC	50 N PERRY ST, 1ST FOOR PONTIAC, MI 48342

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) treatment, the reason(s) why and the intervention taken. 7. The name and title of the individual(s) who performed the procedure. Reporting: 1. Notify the supervisor if the resident refuses the procedure . R#121 On 9/22/20 at 11:30 AM, R#121 was observed lying in bed with an [DEVICE] with pins to the right lower extremity. The resident reported he was recently involved in a car accident and recently admitted to the facility. When asked about the facility's provision of wound care, R#121 reported no one had completed any wound care since admission on 9/17/20 and was unsure how often that should be done. A review of the clinical record revealed R#121 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. There was no completed minimum data set (MDS) assessment completed for review at this time. A review of R#121's admission hospital records documented, .Pt presented to (name of local hospital) on 8/29/2020 s/p (status [REDACTED]. pt was front passenger, front end collision - resulting in air bag deployed .Imaging showed right tibial plateau fracture with associated proximal fibula fracture . A review of R#121's physician orders for wound care since admission included: On 9/18/20, PIN CARE every other day, cleanse around pin, wrap xerofprm <sic> gauze around each pin site and cover with 4x4 drain sponge, then wrap with [MEDICATION NAME] and wrap entire ex-fix with 6 inch ACE wrap .Once A Day Every Other Day. A review of R#121's documentation on the Medication/Treatment Administration Records (MAR/TAR) since admission revealed R#121 the following: A comment documented by Nurse BB on 9/18/20 at 10:45 AM read, Not Administered: Other .done yesterday at hospital. due to be changed tomorrow. The entry sections on the MAR/TAR for 9/19 and 9/21 were left blank (incomplete). There was no further documentation including a progress note that the treatment had been completed, or that the physician had been notified of the missed treatments and/or provided alternate wound care instructions. On 9/22/20 at 1:02 PM, an interview with the assigned nurse (Nurse BB) was conducted. When queried about R#121's pin care, Nurse BB reported, He has pin care every other day. Nurse BB was asked to review the treatment record to see when the pin care was last documented as completed and upon review documentation an electronic notification on the screen read, Last Administered 9/18/20 at 9:00 AM (however documentation on 9/18 reflected wound care was not done on 9/18 since it was done at the hospital on 9/17). When asked why pin care had not been provided since admission, Nurse BB reported she was not sure but would follow up. On 9/23/20 at 9:23 AM, an interview and record review was completed with the Director of Nursing (DON). Upon review of R#121's wound care documentation, the DON confirmed the blank entries and when asked what the facility's process was for missed or delayed treatments, the DON reported, Most treatments I put on day shift. If nurses wanted to pass on to another shift they can. They can change and put in a one-time order. The DON was unable to explain why no one else had identified the concern regarding missed treatments. According to documentation, the last time R#121 had received pin care was at the hospital (5 days earlier). A review of the facility's Wound Care policy dated Reviewed 9/22/20 documented, in part: .The following information should be recorded in the resident's medical record .The type of wound care given .The date and time the wound care was given .The name and title of the individual performing the wound care .If the resident refused the treatment and the reason(s) why .Report other information in accordance with facility policy and professional standards of practice .
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 citation pertains to intake #MI 462. Based on observation, interview and record review, the facility failed to ensure timely/completed assessments and investigations into falls, and identify and implement appropriate fall interventions and supervision for one (R2) of one resident reviewed for falls, resulting in continued falls and the increased potential for falls with serious harm and/or injury. Findings include: A review of complaints reported to the State Agency included allegations that R2 had falls due to lack of adequate supervision due to inadequate staffing. On 9/22/20 at approximately 1:00 PM, R2 was observed seated in a Geri chair recliner with an overbed tray table in front of the resident. R2 was very thin and had long fingernails with dark debris underneath the nail tips. R2 was asked about the lunch meal and although was very slow to respond, stated I'm hungry. Throughout this meal observation, there were no staff observed supervising the resident during the meal. The resident's bed was positioned so that one side was against the wall and there was no mat on the floor next to the bed. Continued observations throughout this survey revealed that although R2's room was across from the nursing station, there were times when there were no staff present in the hallways, or near the nursing station. Staff were observed passing medications and providing care to other residents. During interviews throughout the survey with staff whom requested to remain anonymous, when asked about the ability to adequately supervise residents, concerns were identified that there may not be adequate staff to supervise R2 when care is being provided to other residents. For example, staff reported for a current census of 18, eight of these residents were scheduled for showers which took away time for other residents that needed assistance and/or supervision. When asked about staffing assignments, staff reported at times there was only one nurse, or one CNA and at times only one nurse without any CNA. A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition, required extensive assist of one person for bed mobility, transfers, dressing, personal hygiene and bathing, had two or more falls without injury since the previous MDS assessment on 4/22/20, and received a therapeutic diet. On 9/22/20, the Director of Nursing (DON) was requested to provide any fall documentation for R2 since January 2020, including any investigations completed by the facility. A review of R2's fall documentation provided by the facility identified R2 had 14 fall incidents since admission on 1/16/20. Details of these falls included: Fall #1 on 1/20/20 at 4:54 PM documented, in part: .unwitnessed fall .resident was observed sitting upright on the floor with his back up against the wall. Was trying to use the bathroom .Description of Action Taken .RE (resident) educated to call light .patient has dementia and a history of repeated falls . There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #2 on 1/22/20 at 7:45 PM documented, in part: .CNA (Certified Nursing Assistant) found patient sitting on mat next to his bed at 1945 (7:45 PM) on 1/22/20. CNA called writer to patient's room. Writer observed patient sitting on mat with left arm on nightstand next to his bed. Patient had a clean brief and gown on at time of fall. Writer believes patient was attempting to self-transfer to W/C (wheelchair). W/C was by the foot of bed at time of fall .CNA et <sic> writer picked patient up from floor et <sic> sat in W/C .Neuro checks started .Patient offered snacks and fluids .Patient at time of fall was alert et <sic> oriented x4. Patient has [DIAGNOSES REDACTED].Patient states he fell on his knees and then sat down on mat . There was no documentation provided of any investigation into the fall to identify when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #3 on 1/27/20 at 8:45 PM documented, in part: .Patient had an unwitnessed fall. Patient found sitting on floor mat next to bed. Nonskid socks on et <sic> call light within reach at time of fall. Patient states he was attempting to get out of bed .Neuro checks initiated . There was no documentation provided of any investigation into the fall to identify when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #4 on 1/28/20 at 12:15 AM documented, in part: .Patient was at nurses station conversing with nurse and CNA. Snacks et <sic> fluids offered and accepted by patient. Paper and pen given to patient .Patient asked to be taken to bed because he was tired and sleepy. CNA toileted and assisted patient in bed. A few minutes later a loud noise was heard from patient's room. Staff rushed to room and found patient sitting on mat next to bed with his back to his W/C (wheelchair). Patient states he was trying to get out of bed .Neuro checks re-started .Patient brought to nurses' station and then to common area to watch TV . There was no documentation provided of any investigation into the fall to identify whether interventions had been revised to prevent future fall occurrences. Fall #5 on 2/3/20 at 1:57 PM documented, in part: .Nursing Description (left blank/incomplete) .Resident Description (left blank/incomplete) .No Injury identified .Injury Location 1) Top of Scalp . The section for mental status, predisposing environmental factors, predisposing physiological factors, predisposing situation factors and other information was left blank/incomplete. The section which identified any witnesses did not identify any specific name, only noted as Staff under relation. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #6 on 2/18/20 at 12:18 AM documented, in part: .Resident observed on the floor by the left side of the bed at about 8:30 pm. Resident was assisted to get to the wheelchair .Resident Unable to give Description

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) .No witnesses found . There was no documentation that the resident's representative had been notified of the fall and the physician had been paged but no response. The section for mental status and other info was left blank. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #7 on 4/10/20 at 3:17 AM documented, in part: .Resident observed sitting on the floor mat on the left side of the bed. Resident assisted by on-duty nurse and 2 nurse assistants to get back to bed .Resident unable to give description .Wet his diaper and bed . The section for predisposing situation factors was left blank and the section for people notified documented only the physician had been notified, there was no documentation the resident's representative had been notified. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #8 on 4/16/20 at 10:12 AM documented, in part: .Patient found on floor by bedside sitting on bottom. Writer and CNA picked patient off floor .Resident Unable to give Description .Immediate Action Taken .patient brought to nurses station to be monitored . The section for predisposing situation factors and other info was left blank. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #9 on 6/2/20 at 3:39 PM documented, in part: .attempting to reach trash can . Although there was a check mark next to Care Plan updated there was no identification of what had been updated. The section of this report that identified Closed Date was dated 9/23/2020 03:07PM. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #10 on 7/6/20 at 6:43 PM documented, in part: .Patient had an unwitnessed fall at 1530 (3:30 PM) .Neuro checks initiated .Call light within reach, bed in lowest position, mat continues next to bed . A checklist attached to this report which prompted Update care plan with new immediate intervention documented Need. The section of this report that identified Closed Date was dated 9/23/2020 03:09 PM. There was no documentation provided of any investigation into the fall to identify when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #11 on 7/26/20 at 2:45 PM documented, in part: .Fall .Resident Room .Resident was laying in bed and playing with bed remote . The section for notifications, vitals, orders and notes were left blank/incomplete. The section under evaluation read N/A (not applicable): Event still open. A checklist attached to this report which prompted Progress note .Skin observation eval, Pain eval, Fall risk eval, Neuro-checks, E Interact Change of Condition, Update care plan with new immediate intervention, Post-Fall eval, Place on Communication Report, Nurse completing form were all left blank/incomplete. The section of this report that identified Closed Date was dated 09/23/2020 at 03:10 PM. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #12 on 9/8/20 at 10:10 AM documented, in part: .Fall .Resident Room .Sitting in bed waiting for breakfast . The section for possible contributing factors, interventions, outcome of interventions, notifications to physician and representative were all left blank/incomplete. The section for evaluation read, N/A: Event still open. The section of this report that identified Closed Date was dated 09/23/2020 at 03:11 PM. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #13 on 9/8/20 at 6:52 PM documented, in part: .Fall .Resident Room .Eating Dinner . The section for mental status, possible contributing factors, outcome of interventions, notifications of time and date of physician and representative notification were left blank/incomplete. The section of this report that identified Closed Date read, 09/23/2020 at 03:14 PM. There was no documentation provided of any investigation into the fall to identify what interventions had been in place prior to the fall, when the resident had last been checked, interviews with staff on duty, or whether interventions had been revised to prevent future fall occurrences. Fall #14 on 9/11/20 at 8:00 AM documented, in part: .Pt observed on mat on the side of bed this am. Neuro checks began .MD notified .POC in place (no description of specific interventions) . The section for notifications of time and date of physician and representative notification were left blank/incomplete. The section for evaluation read, N/A: Event still open. The section of this report that identified Closed Date read, 09/23/2020 at 03:15 PM. A review of R2's fall care plan that was available for review documented, in part: Problem Start Date: 06/10/2020 .Resident is at risk for falling R/T (related to): Dementia; cognitive limits; Hx (history of) frequent falls; poor safety awareness; impulsive with transfers; [MEDICAL CONDITION]; poor awareness of body position; medication side effects; (name of R2) had falls at previous facility per family; Updated fall risk at 21. Review of the interventions included: On 9/11/20 Orientate pt to surroundings while making rounds. On 7/27/20 pharmacy med review. On 7/26/20 Observe frequently and place in supervised area when out of bed. On 7/16/20 Pharmacy consultant medication review. On 7/9/20 Wing Tipped Mattress If (name of R2) is restless in the bed please get him up to w/c/geri/cardiac chair. On 6/10/20: Give resident verbal reminders not to transfer without assistance. Check (name of R2) frequently when he is in the bed and remind him not to transfer without help. Keep bed in lowest position with brakes locked. Keep call light in reach at all times. Monitor for any sleeping problems thru the night as he has [MEDICAL CONDITION]. Keep personal items and frequently used items within reach. Leave night light on in room. Provide resident an environment free of clutter. Mats to both sides of the bed on the floor. Provide toileting assistance as needed. Toilet (name of R2) upon waking, before meals and at bedtime; If he is awake after midnight ask if he needs to toilet then. The facility had switched from a previous electronic medical record (EMR) system in June 2020. Upon access to the previous EMR on 9/24/20, the care plan sections were restricted for all residents reviewed, including R2. Unable to verify if/what interventions had been implemented for the falls from January to May 2020. On 9/23/20 at 3:39 PM, the Director of Nursing (DON) was queried about the lack of completion of the incident reports provided for R2 and she reported she had completed them today. When queried about why these assessments were not completed until today, the DON reported there were issues with the switch from EMR systems. When asked about the interventions identified on the care plan to re-educate R2 to use the call light or ask for help before transferring when it was also identified that there were cognitive limitations, impulsive behaviors, and poor safety awareness, the DON offered no response. When asked why there were still no documentation of what had been discussed or reviewed with the interdisciplinary team, what staff had been interviewed about the resident's status prior to the falls, and what interventions had been implemented following each fall, the DON offered no further explanation. When asked about the multiple incident reports that did not identify whether the resident's representative had been notified of the fall incident, the DON offered no further explanation. The DON was requested to provide any further documentation that the facility had adequately and/or thoroughly investigated the resident's falls, reviewed with interdisciplinary team, and identified appropriate interventions. There was no further documentation provided by the end of the survey. A review of the facility's Falls and Fall Risk, Managing policy dated Reviewed 9/24/20 documented in part: .staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling .If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions .The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls .
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 441. Based on observation, interview and record review, the facility failed to ensure ongoing assessment, monitoring, and implementation of nutritional interventions upon identified changes in status for one (R2) of five residents reviewed for nutrition/food, resulting in a severe weight loss (-6.7% in six days) likely due to lack of timely monitoring, reassessment, and implementation of planned interventions, and the increased likelihood for further decline in overall health status. Findings include: A review of the facility's menus for the week which included all therapeutic diets revealed: the lunch meal to be provided on Tuesday 9/22/20 was: tuna casserole, vegetable blend, dinner roll, margarine, orange sherbert, 2% milk, coffee, and hot tea; the breakfast meal to be provided on Wednesday 9/23 was: orange juice, oatmeal, sausage pattie, muffin, margarine, jelly, 2% milk, coffee, and hot tea. (res had only oatmeal,

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	235703	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR NURSING & REHAB CENTER LLC	50 N PERRY ST, 1ST FOOR PONTIAC, MI 48342

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 9) sugar packets and orange juice (thickened). A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition, required supervision with set up for eating, received a mechanically altered diet, had a weight of 155 with no weight changes (either increase or decrease). Review of the previous MDS assessment dated [DATE] documented R2 had a weight of 166 pounds. A review of the interdisciplinary progress notes revealed: On 9/3/20 at 3:56 PM, an entry by Nurse E read, Pt (patient) observed having difficulty while eating. OT (Occupational Therapy) notified. On 9/4/20 at 2:04 PM, an entry by Nurse V read, Pt observed having difficulty while eating. OT notified. A review of the therapy documentation provided by the facility revealed R2 had been seen by occupational therapy four times during the 9/7/20 - 9/17/20 progress period. Therapy documentation completed by OT Staff W read, in part: .pt (patient) scored 10/30 normalized for education level, this score indicated markedly impaired cognition and new learning capability. For this reason, pt would not benefit from further skilled training to increase .independence. Pt will continue to require a substantial amount of supervision and cuing for functional activities due to pathology of medical dx (diagnosis) .Treatment results communicated to Interdisciplinary Team .Discharge Recommendations: Divided plate with dycem, up in chair during all meals to promote self feeding independence and allow pt to live in least restrictive environment .Pt issued divided plate and (namebrand of a non-slip material) for feeding assistance, AE (Adaptive Equipment) given to dietary manager to implement during mealtimes . A review of R2's current physician orders [REDACTED]. Ordered 9/11/20, Pt (patient) to be up in cardiac chair and supervised during mealtimes. With Meals 08:00 AM, 12:00 PM, 06:30 PM. Ordered 9/11/20, Pt to use divided plate placed on (namebrand of a non-slip material) during mealtimes. With Meals 08:00 AM, 12:00 PM, 06:30 PM. On 9/22/20 at approximately 1:00 PM, R2 was observed seated in a gerichair recliner with an overbed tray table in front of the resident. R2 was very thin and had long fingernails with dark debris underneath the nail tips. R2 repeatedly attempted to scoop up orange liquid that had spilled all over the food tray with a spoon and fingers. There were two small food bowls, one had green colored pureed food (vegetable blend) and one had tan colored pureed food (tuna casserole). The only other food on the meal tray was an empty container of ice cream (orange colored which had melted over the entire meal tray). There was no divided plate or non-slip material utilized. Further review of the meal ticket on the meal tray documented R2 was to receive pureed foods with large portions and nectar-thick coffee (although the double portions were not specified in the physician orders). R2 was asked about the lunch meal and although was very slow to respond, stated I'm hungry. Throughout this meal observation, there were no staff observed supervising the resident during the meal. On 9/23/20 at 8:45 AM, Nurse F was observed to enter R2's room (resident was already observed eating the breakfast meal), obtain a blood pressure reading and immediately exited the room. On 9/23/20 at 8:47 AM, R2 was observed seated in a gerichair recliner with an overbed tray table in front of the resident. R2's breakfast meal consisted of two containers of oatmeal, three unopened sugar packets and thickened orange juice. R2 attempted to scoop oatmeal from the small container which slid around the meal tray. There was no divided plate, non-slip material, nor was there any protein item (such as the sausage) provided on the meal tray. On 9/23/20 at 8:49 AM, Certified Nursing Assistant (CNA B) was queried about R2's breakfast meal and what food was usually provided. CNA B confirmed there was only oatmeal, sugar packets and orange juice on the meal tray and reported, It's oatmeal, usually give yogurt and applesauce. When asked about whether R2 used a divided plate with non-slip material, CNA B denied being aware of the resident's need for either item. When asked how information was provided to staff of resident's specific care needs, CNA B reported there was a care guide in the (name of current electronic medical record/EMR) system. At that time, CNA B was asked to access R2's care guide via the EMR and upon review confirmed there was an order for [REDACTED]. CNA B proceeded to follow up with the Dietary & Housekeeping Manager (Staff J). On 9/23/20 at 8:57 AM, Staff J was observed walking into R2's room while holding a divided plate still encased in a plastic covering. When asked about the divided plate, Staff J reported, The problem is we (facility) don't do the dishes. This (pointed to divided plate in plastic) was on my desk. Problem is we don't wash our own dishes (resident dishware sent to another facility for cleaning) then it's brought back later. So at the end of the day, this was not available. When asked about the resident's lack of protein or nutritional shakes provided with the breakfast meal, Staff J reported There is sausage. When asked if there was more than one divided plate available to ensure R2 did not go without at all meals, Staff J offered no further response. When asked if residents on pureed diet would receive sausage in pureed form, Staff J reported, (R2) should've received even if pureed. I can get him some. On 9/23/20 at 9:10 AM, Staff J was observed to provide R2 a divided plate which had the small food bowls of oatmeal and applesauce placed directly on top of the divided sections of the plate (food was not directly placed into the divided plate). Continued observation of the breakfast meal revealed Staff J did not ask the resident if they wanted any additional food and did not provide any additional food such as the sausage mentioned earlier, or a nutritional shake. On 9/23/20 at approximately 10:30 AM, an interview was conducted with RD C. When queried about R2's weight and nutritional status and whether there were any reported concerns for R2's such as decreased oral intake, difficulty eating, or ability to feed self, RD C denied being aware of any recent concerns or changes. RD C was requested to obtain and observe a current weight. On 9/23/20 at approximately 10:50 AM, an observation of R2's weight revealed a current weight (taken while R2 stood on the scale) as 133.4 pounds. The last documented weight for R2 was on 9/17/20 as 143 pounds (a severe weight loss of 6.71% in six days; facility policy noted 5% in one month was considered severe). On 9/23/20 at 11:04 AM, RD C was requested to provide any additional documentation regarding R2's weights, assessments and care plans as the facility had previously used another EMR system prior to June 2020. RD C was asked about the 10 pound weight loss in just under one week and did not offer any further response or explanation. On 9/23/20 at 11:25 AM, RD C confirmed the last documented nutritional assessment was completed on 7/23/20. When asked about the observation of the orange liquid observed at the lunch meal on 9/22/20, RD C reported, That (orange sherbert) does not come in nectar thick consistency and (R2) should not have received the orange sherbert, but should've had a nutritional supplement. When asked to clarify what kind of supplement, RD C stated, It's usually a mighty shake that's thickened. When asked about the discrepancy between the meal ticket which documented double portions, and what was observed provided to R2, RD C stated, That is not double portions. A review of R2's nutritional documentation provided by RD C included: A nutrition care plan which had been initiated 6/10/20, with no further revisions/interventions implemented. This care plan documented, in part: Problem Start Date: 06/10/2020 .Resident has potential alteration in nutritional status R/T (related to) PMH (past medical history) of: DYSPHAGIA; [MEDICAL CONDITION]; IS ON MECHANICALLY ALTERED DIET of Puree with nectar thick liquids. New baseline weight is 140#. Res is able to stand. An Activities of Daily Living (ADL) care plan initiated 6/10/20 included interventions that read, Approach Start Date: 09/22/2020, divided plate with meals and Approach Start Date: 09/22/2020 dycem to w/c (wheelchair); up for meals. R2's nutrition assessments (most recently completed by RD C on 7/23/20 at 3:50 PM) documented, Res presents with change in weighing method from wheelchair to standing resulting in a significant weight change of 10.7%, will reweigh again and weigh weekly x 4 weeks to ensure that new baseline weight is accurate. There have been no reports of declining appetite and resident is alert and can hold conversation, can tell you what he likes and he can feed himself with set up. Res is provided a puree diet with NTL's (nectar thick liquids) which has been tolerated well for some time. Res current weight is 140# which resident remembered and he was able to recall that he stood and explained that people didn't know he can stand. As a precaution, will add a supplement at lunch and follow weight again x 1 week. There was no further nutritional assessment by RD C since this assessment, or following identified changes as reported by nursing on 9/3 and 9/4. R2's weights provided by RD C included: 6/7/20=155 pounds (lbs); 7/23/20=140 lbs; 7/30/20=140 lbs; 8/6/20=140.1 lbs; 9/17/20=143. The weights were not completed weekly x 4 as indicated in the nutrition assessment on 7/23/20 (no weight from 8/7/20 - 9/16/20). There were no weights provided prior to 6/7/20 as requested since R2's admission. On 9/23/20 at 12:22 PM, RD C was asked about the lack of revised interventions since 6/10/20 and nutritional assessment following the 7/23/20 assessment, RD C provided no response. When asked if there was any physician involvement or notification regarding any unintended weight loss, difficulty eating, or nutritional concerns for R2, RD C stated, No. I'm only here one time a week. We do (review) at risk weekly meetings, the DON (Director of Nursing) will identify and notify the physician. At that time, RD C was requested to provide any physician documentation for follow up for R2's nutritional needs and reported he would follow up. On 9/24/20 at 11:00 AM RD C provided additional documentation which included a restorative care program following R2's recent discharge from Occupational Therapy with an effective date of 9/11/2020 which read, Goals for Restorative Program: 1) Preserve pt's (patient's) ability to self-feed safely and effectively to decrease risk of malnutrition. Approach/Recommendations for implementation for above goals: 1) Pt to be up in geri-chair and supervised during meal times 2) pt's food to be served on divided plate placed on (namebrand of non-slip material) Precautions or Comments to this program: puree diet, nectar-thick liquids. This form was only signed by the therapist on 9/11/20 and the section of the form for the restorative nurse/aide was left blank. On 9/24/20 at 11:24 AM, the

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 10) DON was asked about the facility's restorative care program and reported, We all do it (restorative). When asked if the facility had a restorative program, the DON reported, We just put the order in we don't actually have a restorative program. When asked about the recommendation for increased supervision with meals and informed of the lack of supervision with meals throughout the survey, the DON offered no response. On 9/24/20 at 11:51 AM, Therapy Manager D was asked about the facility's process following resident's completion of therapy and recommendations for nursing and reported, When done with therapy, nurses put in order to follow whatever recommendation was identified. Not aware of an actual restorative program here. A review of the documentation provided by the facility included the following policies: A Nutritional Assessment policy dated Reviewed 9/23/2020 documented, in part: .The Dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident .and as indicated by a change in condition that places the resident at risk for impaired nutrition . A Nutrition (Impaired)/Unplanned Weight Loss policy dated Reviewed 9/23/2020 documented, in part: .The threshold for significant unplanned and undesired weight loss will be based on the following criteria .1 month - 5% weight loss is significant; greater than 5% is severe .The Physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include .Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals .
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** Based on observation, interview and record review, the facility failed to ensure the resident was consistently treated for [REDACTED].#17) of two residents reviewed for pain management, resulting in resident experiencing pain and omitted [MEDICATION NAME] prescribed by the physician. Findings Include: On 9/22/20 at 9:41 a.m., when asked about pain management at the facility, R#17 stated, Sometimes I get medication for pain. I have to ask for it to get it for my shoulder, knee, and back. When asked if they were on scheduled pain medication, R#17 stated, I'd like to be on scheduled medication. I don't get my [MEDICATION NAME] like I'm supposed to, only if I ask for it. When asked if they were in pain at that time, and where was their pain, R#17 stated, Yes, my shoulder, knee, and back. R#17 was asked to rate their pain, and stated, It's about an 8 (out of 10). Review of the clinical record revealed R#17 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#17 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. The MDS further revealed in Section J (J0100) Pain Management - PAIN: Received scheduled pain medication regimen? No. Received PRN pain medications OR was offered and declined? No. Received non-medication intervention for pain? No. Should Pain Assessment Interview be Conducted? Yes. Pain Presence? No . Resident #17's Care Plan for Pain revealed the following: Problem Start Date: 05/15/2019 Category: Pain (R#17) has risk for alteration in comfort R/T (related to): left knee surgery, DJD ([MEDICAL CONDITION] Joint Disease); she has prn (as needed) pain medication My acceptable level of pain is :1 Goal: Long Term Goal Target Date: 11/21/2020 (R#17) will verbalize pain relief or acceptable level of pain / signs of pain will be diminished or absent through the review. Approach: Start Date: 05/15/2019 Administer pain medication as ordered and monitor side <sic> for side effects. physician's orders [REDACTED]. (DX: Spinal stenosis, lumbosacral region) Remove [MEDICATION NAME] Patch from back At Bedtime 06:00 PM 08/31/2020 Open Ended Bio freeze (menthol) (menthol) (OTC) gel; 5 %; amt: 2 gm (gram); topical As Needed .06/18/2020 Open Ended [MEDICATION NAME] - Schedule II tablet; 10 mg (milligram); amt: 10 mg; oral Special Instructions: As needed Q (every) 6 hr. for pain. Hold for sedation As Needed .06/04/2020 Open Ended Bio freeze 4% apply to left knee every shift Every Shift 07:00 AM - 07:00 PM, 07:00 PM - 07:00 AM 5/31/2020 Bio freeze 4% apply to right shoulder every shift Every Shift 07:00 AM - 07:00 PM, 07:00 PM - 07:00 AM 05/31/2020 Open Ended Ice/Hot pack as needed for knee pain per therapy 05/31/2020 Open Ended Pain assessment every shift Every Shift 07:00 AM - 07:00 PM, 07:00 PM - 07:00 AM 05/31/2020 Open Ended. Review of R17's Medication Administration Record [REDACTED]. Comment: Did not have time 09/08/2020 6:00 AM 09/08/2020 06:19 AM Not Administered: Drug/Item unavailable 09/09/2020 6:00 AM 09/09/2020 05:49 AM Not Administered: Drug/Item unavailable 09/10/2020 6:00 AM 09/10/2020 07:39 AM Late Administration: Charted late. Comment: charted late 09/12/2020 6:00 AM 09/12/2020 06:14 AM Not Administered: Drug/Item unavailable 09/14/2020 6:00 AM 09/14/2020 06:06 AM Not Administered: Drug/Item unavailable 09/16/2020 6:00 AM 09/16/2020 07:46 AM Late Administration: Charted late. Comment: charted late 09/18/2020 6:00 AM 09/18/2020 06:47 AM Not Administered: Drug/Item unavailable 09/19/2020 6:00 AM 09/19/2020 05:53 AM Not Administered: Drug/Item unavailable 09/20/2020 6:00 AM 09/20/2020 05:57 AM Not Administered: Drug/Item unavailable 09/22/2020 6:00 AM 09/22/2020 05:36 AM Not Administered: Drug/Item unavailable 09/23/2020 6:00 AM 09/23/2020 05:26 AM Not Administered: Drug/Item unavailable On 9/23/20 at 10:48 a.m., during an interview and observation of the medication cart along with Registered Nurse (RN) 'F' to check for R#17's [MEDICATION NAME]es. The [MEDICATION NAME]es were not on the medication cart. When queried why R#17 did not have any [MEDICATION NAME]es on the medication cart, and if there was a physician order, RN 'F' stated, It ([MEDICATION NAME]) is put on by the midnight nurse. At that time, an observation of the medication room was conducted along with RN 'F'. RN 'F' stated, I don't see any, and confirmed there were no [MEDICATION NAME]es in the medication room. On 9/23/20 at 11:15 a.m., R#17 was observed in bed. When asked if they had received their [MEDICATION NAME] that morning, R#17 stated, No, they only gave me Bio freeze. When asked if they were experiencing any pain, R#17 stated, Yes, my shoulder, back, and my knee. When asked to rate the level of their pain, R#17 stated, between a 7 or 8. On 9/23/20 at 12:51 p.m., during a phone interview with RN 'P', when asked why R#17's [MEDICATION NAME] was documented as administered late or unavailable, RN 'P' stated, It was not available, I put it on the MAR for the pharmacy, but pharmacy haven't been able to fill it. When asked why the Pharmacy was not able to fill R#17's [MEDICATION NAME], RN 'P' stated, I work 7pm to 7am, by the time we come (to work), they are already closed. RN 'P' was queried if that information was relayed to the oncoming shift nurse, RN 'P' stated, Yes, but the Pharmacy hasn't been able to get it. On 9/23/20 at 1:05 p.m., an interview was conducted with the Medical Director. When asked about R#17's [MEDICATION NAME] that was unavailable, the Medical Director stated, If it's not available, there is nothing we can do. It could be their insurance. If Pharmacy doesn't have it .we'll call Pharmacy. I want someone to look into it. On 9/23/20 at 1:10 p.m., the Medical Director called Pharmacy. During that conversation, Pharmacy Representative 'T' stated, It's not covered so they have been pulling it from the back up. At that time, the Medical Director stated, I will try to get a prior authorization .Why didn't Pharmacy notify us (facility)? During a review of the MAR, the Medical Director did not have an explanation for all of the documented Not Administered: Drug/Item unavailable entries. When asked about the one entry that was documented on 09/07/2020 6:00 AM 09/07/2020 07:00 AM Not Administered: Drug/Item unavailable. Comment: Did not have time, the Medical Director stated, What is that? Who is that nurse? On 9/23/20 at 1:15 p.m., during an interview with the DON, when queried what was the facility's protocol when residents' pain medication is unavailable for the nurses to administer/apply, the DON stated, Pharmacy should notify us that they need a prior authorization or if it is not covered for long term care residents. On 9/23/20 at 1:20 p.m., when asked if there was any notification on file from Pharmacy regarding R#17's [MEDICATION NAME], the Administrator stated, Usually it comes through the fax or they call us. That information was not provided by the end of the survey. A review of the facility's policy titled Pain Assessment and Management - Nursing Procedures revised 9/28/20 read in part as follows: Purpose: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines: 1. The pain management program is based on a facility-wide commitment to resident comfort . The policy titled Administrating Medications - Protocols and Standards revised 9/22/20 read in part as follows: Policy Statement: Medications will be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation .2. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified .18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication will initial and circle the MAR indicated [REDACTED]. Topical medications used in treatments must be recorded on the resident's treatment record (TAR) .
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**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 intake #s MI 441 and MI 462. Based on observation, interview and record review, the facility

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 11) failed to provide adequate nursing staff to meet resident needs, resulting in inadequate care for activities of daily living care needs such as nail care, hygiene, and supervision to prevent falls for R2. This deficient practice has the potential to affect all 17 residents who resided in the facility. Findings include: A review of complaints reported to the State Agency included allegations that identified inadequate staffing levels on multiple dates in which there was only one nurse and no certified nursing assistants (CNAs) assigned for a census of 17 residents, or one nurse and one CNA. The complainant further alleged that due to inadequate staffing, residents were not receiving the proper supervision which resulted in falls, and daily care needs were not being provided such as toileting, hygiene, grooming, and incontinence care. On 9/24/20 at 11:16 AM, the Human Resource Manager (HR) was requested to provide open nursing staff positions by shift as well as actual timecard reports for 9/2, 9/8 and 9/11/20. At that time, the HR Manager reported there were multiple openings and would follow up. On 9/24/20 at 1:26 PM, review of the documentation provided by the HR Manager revealed the following open nursing staff positions: CNAs: Day shift: 3 full-time, 4 part-time, 1 contingent; Night shift: 2 full-time, 1 part-time. Nurses: Day shift: 1 part-time; Night shift: 2 full-time, 1 part-time. A review of the daily assignment documentation verified by nursing staff's actual timecard reports revealed the following: On 9/2/20 day shift: There were 2 nurses assigned, but 1 nurse worked 7:05 AM - 7:26 PM and the other nurse worked 7:00 am - 11:00 am. There was no other nurse until the night shift which started at 7:09 PM. There were no CNAs assigned for the day shift until one CNA began work at 2:35 PM. There was no other CNA until the night shift which started at 6:51 PM. On 9/8/20 day shift: There was one nurse assigned that began work at 6:45 AM until 1:23 PM and 1:49 PM until 7:54 PM. The next assigned nurse began at 7:02 PM. There was only one CNA assigned that began work at 7:20 AM until 12:12 PM. The next assigned CNA began at 8:08 PM. On 9/11/20 day shift: There was one nurse assigned that began at 7:18 AM. The next assigned nurse began at 6:55 PM. There was one CNA that began at 6:57 AM. There was one CNA that began at 9:59 AM until 12:31 PM. The next assigned CNA began at 6:54 PM. During interviews throughout the survey with staff whom requested to remain anonymous, when asked about the ability to adequately supervise residents, concerns were identified that there may not be adequate staff to supervise R2 when care is being provided to other residents. For example, staff reported for a current census of 18 (another admission since start of survey), eight of these residents were scheduled for showers which took away time for other residents that needed assistance and/or supervision. When asked about staffing assignments, staff reported at times there was only one nurse, or one CNA and at times only one nurse without any CNA. Resident (R2): On 9/22/20 at approximately 1:00 PM, R2 was observed seated in a Geri chair recliner with an overbed tray table in front of the resident. R2 was very thin and had long fingernails with dark debris underneath the nail tips. R2 was asked about the lunch meal and although was very slow to respond, stated I'm hungry. Throughout this meal observation, there were no staff observed supervising the resident during the meal. The resident's bed was positioned so that one side was against the wall and there was no mat on the floor next to the bed. Continued observations throughout this survey revealed that although R2's desk was across from the nursing station, there were times when there were no staff present in the hallways, or near the nursing station. Staff were observed passing medications and providing care to other residents. During interviews throughout the survey with staff whom requested to remain anonymous, when asked about the ability to adequately supervise residents, concerns were identified that there may not be adequate staff to supervise R2 when care is being provided to other residents. For example, staff reported for a current census of 18, eight of these residents were scheduled for showers which took away time for other residents that needed assistance and/or supervision. When asked about staffing assignments, staff reported at times there was only one nurse, or one CNA and at times only one nurse without any CNA. A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition, required extensive assist of one person for bed mobility, transfers, dressing, personal hygiene and bathing, had two or more falls without injury since the previous MDS assessment on 4/22/20, and received a therapeutic diet. On 9/22/20, the Director of Nursing (DON) was requested to provide any fall documentation for R2 since January 2020, including any investigation completed by the facility. A review of R2's fall documentation provided by the facility identified R2 had 14 fall incidents (unwitnessed) since admission on 1/16/20. Details of these falls included immediate intervention to place at nursing station for increase supervision due to frequent attempts to get up without assistance. Three of these falls occurred on 9/8/20 and 9/11/20 which were identified in the aforementioned nurse staff assignments as dates of minimal nursing staff assigned. A review of R2's fall care plan that was available for review included interventions to observe frequently and place in supervised area when out of bed. On 9/23/20 at 3:39 PM, the Director of Nursing (DON) was queried about the lack of supervision for R2 and reported staffing challenges throughout the past six months due to COVID-19. The DON was asked how staff were able to adequately provide supervision for residents that required increased supervision and reported it was a challenge but they (facility) tried their best. The DON further reported that she had been assigned to work as a nurse to cover when staff called in or had to leave (was working as the only nurse on 9/21/20 when the survey started). On 9/24/20 at 4:00 PM, the Administrator was informed of the concerns regarding lack of adequate staffing to ensure residents were provided with adequate supervision and daily care needs were met. The Administrator reported that they were working on hiring more staff. A review of the facility's Staffing policy dated 9/24/20 documented, in part: .Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met .
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was free from unnecessary [MEDICAL CONDITION] medication for one (R121) of six residents reviewed for [MEDICAL CONDITION] medication use, resulting in R121 remaining on psychoactive medication without documented clinical rationale for as needed (PRN) medication beyond 14 days, without documented resident specific targeted behaviors and documented attempts of non-pharmacological interventions prior to administration of the PRN [MEDICAL CONDITION], and the increased likelihood of serious side effects, adverse reactions and inability to monitor the effectiveness of the prescribed treatment due to lack of documented supporting evidence. Findings include: On 9/22/20 at 11:30 AM, R121 was observed lying in bed with an [DEVICE] with pins to the right lower extremity. The resident reported he was recently involved in a car accident and recently admitted to the facility. Throughout the interview, R121 repeatedly inquired about when he would receive [MEDICATION NAME] (not currently prescribed). R121 was informed that question would be reviewed with the nurse. R121 further reported wanting to discharge soon but was unable to due to need for intravenous antibiotics. A review of the clinical record revealed R121 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of R121's admission hospital records documented, .Pt presented to (name of local hospital) on 8/29/2020 s/p (status [REDACTED]. pt was front passenger, front end collision - resulting in air bag deployed .Imaging showed right tibial plateau fracture with associated proximal fibula fracture. Pt states he quit [MEDICATION NAME] after [AGE] years only 5 weeks ago. Pt (patient) drinks a pint of alcohol daily, tried to quit alcohol 4 days ago .Patient states that he has history of Heroin .last used .in 1985 . A review of R121's physician orders [REDACTED].End Date: Open Ended. A review of the Medication Administration Records (MARs) since admission revealed R121 received the following 9 doses of [MEDICATION NAME] prn: On 9/19 at 1:56 AM, PRN Reason: Other; Comment: agitated. On 9/19 at 1:28 PM, PRN Reason: Other; Comment: patient requesting r/t restlessness and anxiety. On 9/21 at 9:07 AM, PRN Reason: Other; Comment: c/o restlessness. On 9/21 at 8:46 PM, PRN Reason: Other; Comment: anxiety. On 9/23 at 6:18 AM, PRN Reason: Other; Comment: anxiety. On 9/23 at 4:32 PM, PRN Reason: Other; Comment: anxiety, given per resident request. refused other interventions (not identified what other interventions were attempted). On 9/24 at 9:00 AM, PRN Reason: Behavior issue; Comment: anxiety. On 9/26 at 10:37 PM, PRN Reason: Pain; Comment: resident request. On 9/28 at 6:35 AM, PRN Reason: Other; Comment: resident request. A review of R121's [MEDICAL CONDITION] drug use care plan initiated 9/17/20 documented, Resident is at risk for adverse consequences R/T (related to) receiving (antidepressant, antianxiety and antipsychotic; (name of R121) has dx (diagnosis) of anxiety, depression, ETOH and [MEDICAL CONDITION]; (name of R121) was here several years ago, and left AMA (against medical advice); he continues to make statements that he wants to leave again

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 12) AMA but has not so far. Interventions included: Try non-pharmacological interventions before initiating drug therapy. Observe and document the resident's mood / behavior. These interventions did not identify what the resident specific targeted mood or behaviors were, or what resident specific non-pharmacological interventions were to be attempted. Further review of the clinical record, including interdisciplinary progress notes revealed there was no further documentation of R121's specific behaviors that warranted use of the prn [MEDICAL CONDITION] medication, or what, if any non-pharmacological approaches had been attempted and failed prior to administering the PRN doses of [MEDICATION NAME]. On 9/23/20 at 9:23 AM, the Director of Nursing (DON) was queried about the facility's process for PRN [MEDICAL CONDITION] medication and reported, There should be an end date. When asked if there should be documented resident specific targeted behaviors and non-pharmacological approaches prior to administering the PRN [MEDICAL CONDITION] medication, the DON reported, Yes. Upon review of the MAR indicated [REDACTED]. The DON was asked if agitation was an appropriate indication to give PRN [MEDICAL CONDITION] medication and reported, No. Should have described what was happening. A review of the facility's [MEDICAL CONDITION] Medication Use policy dated Reviewed 8/2020 documented, in part: .Prior to initiating [MEDICAL CONDITION] medication use, non-pharmacological interventions will be attempted for relief of symptoms. Non-pharmacologic interventions attempted and resident response should be documented .Nursing staff will document in detail an individual's target symptom(s) .Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing [MEDICAL CONDITION] medication .[MEDICAL CONDITION] medication will not be used if the only symptoms are one or more of the following .Restlessness .Mild anxiety .Uncooperativeness .Verbal expressions or behavior that are not due to conditions listed above under Indications and do not represent a danger to the resident or others .PRN orders for [MEDICAL CONDITION] medications may not exceed 14 days unless the prescriber documents rationale for the longer duration .
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review the facility failed to ensure a medication error rate of less than five percent when three medication errors were observed from a total of 25 opportunities for two (R#'s 2 and 9) of six residents observed during medication administration, resulting in a medication error rate of 12%. Findings include: On 9/22/20 at 8:15 am, a medication administration observation of Licensed Practical Nurse (LPN) V administering medications was completed. At 8:39 am, LPN V was observed to have opened a [MEDICATION NAME] 60mg capsule and a [MEDICATION NAME] 0.4 mg capsule, both medication blister packs contained labels that documented do not chew or crush. At 8:51 am, LPN V was observed to have administered the contents of the [MEDICATION NAME] and [MEDICATION NAME] in applesauce to R#2. On 9/22/20 at 9:59 am, the resident physician orders [REDACTED]. [MEDICATION NAME] capsule, delayed release 60 mg, once a day (a delayed release capsule is designed to delay the release of the medication once consumed). The manufacturer's administration instructions document in part .Swallow [MEDICATION NAME] whole; do not crush or chew, do not open capsule . Tamsulosin 0.4 mg capsule, once a day. The manufacturer's administration instructions document in part .Do not crush, chew or open [MEDICATION NAME] capsules . On 9/23/20 at 8:06 am, a medication administration observation of LPN F administering medications was completed. LPN F was observed to have returned from the back up supply room with a new [MEDICATION NAME] Pen for R#9. LPN F drew up seven units (without priming the pen) and proceeded to R#9's room. The manufacturer's instructions documents in part .Prime your pen, turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears . LPN F was observed to have administered the insulin to the resident left arm. After the pen dial went down, the nurse immediately removed the pen from the resident's skin. (Per the manufacturer's instructions which documents in part .Insert the needle. Press and hold the dose button. After the dose counter reaches 0, slowly count to 6 .Please note that if the needle is removed before the 6-second count is completed after the dose counter returns to 0, then underdosing may occur by as much as 20%, resulting in the need for increasing the frequency of checking blood sugar and possible additional insulin administration . Additionally, LPN F did not date the newly opened pen. A facility policy titled Administrating Medications (revised date of 9/22/20) documented in part .Medications will be administered in a safe and timely manner, and as prescribed .The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. Medications must be administered in accordance with the orders, including any required time frame .When opening a multi-dose container, the date opened will be recorded on the container .Each nurses station will have a current Physician's Desk Reference (PDR) and/or other medication reference . A facility policy titled Insulin Administration (revised 9/22/20) documented in part .The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medications sheet and physician's orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protective's 5.2, 5.2.3. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. This deficient practice could affect 15 occupants in the event of fire with evacuation into the stairwell. Findings Include: On September 24, 2020 at approximately 11:25 AM record review revealed the facility annual fire door inspection indicated the South East Stairwell fire door does not close and positively latch. This could potentially allow smoke and heat into the emergency egress stairwell. These findings were confirmed through interview with the maintenance director at the time of discovery.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 441. Based on observation, interview and record review, the facility failed to provide food in the prescribed texture/consistency for one (R2) of five residents reviewed for nutrition/food, resulting in the increased potential for episodes of choking and aspiration to occur. Findings include: A review of the facility's menu for the week which included all therapeutic diets revealed: the lunch meal to be provided on Tuesday 9/22/20 was: tuna casserole, vegetable blend, dinner roll, margarine, orange sherbet, 2% milk, coffee, and hot tea. A review of the clinical record revealed R2 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R2 had moderately impaired cognition, required supervision with set up for eating, and received a mechanically altered diet. A review of R2's current physician orders [REDACTED]. On 9/22/20 at approximately 1:00 PM, R2 was observed seated in a Geri chair recliner with an overbed tray table in front of the resident. R2 was very thin and repeatedly attempted to scoop up orange colored liquid that had spilled all over the food tray with a spoon and fingers. There were two small food bowls, one had green colored pureed food (vegetable blend) and one had tan colored pureed food (tuna casserole). The only other food on the meal tray was an empty container of ice cream (orange colored liquid which had melted over the entire meal tray). Further review of the meal ticket on the meal tray documented R2 was to receive pureed foods with large portions and nectar-thick coffee. On 9/23/20 at 11:25 AM, Registered Dietician (RD) C was asked about the observation of the orange colored liquid observed at the lunch meal on 9/22/20 and reported, That (orange sherbet) does not come in nectar thick consistency and (R2) should not have received the orange sherbet, but should've had a nutritional supplement. When asked to clarify what kind of supplement, RD C stated, It's usually a mighty shake that's thickened. A nutrition care plan which had been initiated 6/10/20, with no further revisions/interventions implemented. This care plan documented, in part: Problem Start Date: 06/10/2020 .Resident has potential alteration in nutritional status R/T (related to) PMH (past medical history) of: DYSPHAGIA; [MEDICAL CONDITION]; IS ON MECHANICALLY ALTERED DIET of Puree with nectar thick liquids . R2's nutrition assessments (most recently completed by RD C on 7/23/20 at 3:50 PM) documented,

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F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 13) .Res is provided a puree diet with NTL's (nectar thick liquids) which has been tolerated well for some time . A review of the facility's Therapeutic Diets policy dated Reviewed 9/23/2020 documented, in part: .Residents on therapeutic diets will not receive extra or reduced portions or modifications that are not part of the diet, unless approved by the Attending Physician in conjunction with the Clinical Dietitian .
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on interview and record review, the facility failed to maintain complete and readily accessible medical records for 17 of 17 residents sampled (R#s 2, 5, 6, 7, 9, 17, 19, 70, 71, 120, 121, 122, 123, 124, 125, 126, and 171), resulting in the facility staff and providers not having access to all of the pertinent information to care for the residents, and the increased potential for mismanagement and unmet resident care needs. Findings include: On 9/21/20 at 12:40 PM, an entrance conference was conducted with the Director of Nursing (DON) who reported the Administrator was on the way back to the facility. At that time, the DON was requested to provide login information to be able to access the facility's electronic medical record (EMR) system. The DON reported the facility had recently changed EMR systems in June 2020. On 9/21/20 at 1:58 PM, the Administrator was sent an email notification requesting required survey documents, including access to the facility's EMR system. As of 9/24/20 at 8:45 AM, there was still no access to the facility's previous EMR system. On 9/24/20 at 8:55 AM, Corporate Staff (Staff R) was queried about the concern that not only was the EMR not available for review as of this time, but how did other staff and physicians coordinate care if they also did not have access and reported, I understand. I'm aware of the concerns. We are working on that now. On 9/24/20 at 9:11 AM, the Administrator reported there should be full access to the previous EMR system. On 9/24/20 at 9:13 AM, Staff R provided a list of residents (currently in the facility) and reported these residents were available for review. At that time, Staff R was informed that the survey team required access to all residents as there were investigations that needed to be completed which included discharged residents prior to the EMR change in June 2020. Staff R requested a list of names of these residents and was informed that was not possible and access should be available for all residents. On 9/24/20 at 9:20 AM, Staff R provided login access for the previous EMR system. At that time, upon accessing the previous system, although most of the information was available, access to care plans was restricted. On 9/24/20 at 9:24 AM, during a phone interview with the Medical Director via the DON's cell phone, when asked about access to a consultation for R6 in the previous EMR system, the Medical Director reported not being able to see that particular consult at the time the resident had been evaluated. Both were informed that was one of the concerns with the facility's inability to provide access to the previous EMR system for review of all residents both discharged and current. As of 9/28/20 at 5:00 PM, there were continued restrictions to portions of the previous EMR system for all sampled residents (R#s 2, 5, 6, 7, 9, 17, 19, 70, 71, 120, 121, 122, 123, 124, 125, 126, and 171). A review of the facility's Medical Records policy dated Reviewed 9/24/20 documented, in part: .The medical director will advise the facility administrator and Medical Records consultant about various medical records policies that impact practitioners, including chart organization, record storage, availability of closed records, and medical content of the medical record .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement adequate infection control practices per protocol, and policies for six (R#'s: 9, 17, 18, 120, 121, and 171) of six residents reviewed for infection prevention and control practices, resulting in a resident who left the facility for a doctor's appointment and returned to their room with their roommate without being placed on isolation precautions; staff not donning/doffing PPE (Personal Protective Equipment) per CDC (Center for Disease Control) guidance; disposal of used lancet (which contained the resident's blood) that was thrown into the resident's bedside garbage container; failing to clean/disinfect a glucometer after use, and no receptacles to dispose of dirty PPE placed at the door before exiting the resident's room. Findings Include: According to the current CDC guidance: .Personal Protective Equipment (PPE) .Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools .Make necessary PPE available in areas where resident care is provided. Facilities should have supplies of facemask, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP/Health Care Professional), gowns, gloves, and eye protection (i.e., face shield or goggles) .Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room .Implement a process for decontamination and reuse of PPE such as face shields and goggles .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents .Roommates of residents with COVID-19 should be considered exposed and potentially infected .HCP should use all recommended COVID-19 PPE for the care of all residents on affected units .this includes both symptomatic and asymptomatic residents . Resident #17: Review of the clinical record revealed R#17 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#17 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. On 9/21/20 at 3:30 p.m., R#17 was observed to be out of their room. When queried about their absence, the Director of Nursing (DON) reported that R#17 was out of the building at an appointment. Review of the clinical record revealed R#17 had an appointment on 9/21/20 at 11:30 a.m., for an EEG (Electroencephalogram - a test used to evaluate the electrical activity in the brain). When R#17 returned from their doctor's appointment, they were observed in their same room with their roommate. R#17 was not placed on isolation precautions. On 9/22/20 at 2:05 p.m., during an interview with Receptionist 'U', when asked who was responsible for scheduling outside appointments for residents at the facility, Receptionist 'U' explained that they had only been working at the facility since July, and they kept a log of all of the residents' appointments. When asked how residents are received back into the facility when they return from their outside appointments, Receptionist 'U' explained that they screen the residents (take their temperature) and then they go back to their rooms. On 9/23/20 at 9:00 a.m., the Director of Nursing (DON) was queried if residents are placed on isolation precautions when they return to the facility from an outside appointment. The DON stated, No, they are not. At that time, the DON was queried about the facility's protocol and infection prevention and control practices to prevent the spread of infectious diseases/viruses. On 9/23/20 at 11:45 a.m., R#17's door was observed closed and there was an isolation precaution sign on the door. Both residents were in the room. At that time, the DON was gathering PPE to put into a bin, and place outside of the room. The DON explained she was preparing for isolation precautions and both R#17 and their roommate was going to be on isolation precautions. The DON further stated, since R#17's roommate was in the room when they returned from their outside appointment, the roommate would have to be placed on isolation precautions as well. When asked about the facility's isolation precautions after the return of outside appointments, the DON did not have an explanation. On 9/21/20 at 12:40 PM, an interview was conducted with the Director of Nursing (DON) who also reported she was responsible for overseeing the facility's infection control practices. At that time, the DON reported there were no current COVID-19 positive residents but reported there were several that were on droplet isolation precautions for 14 days due to new or readmission status. When asked what PPE should be worn when providing care for those residents, the DON reported, A facemask. On 9/21/20 at 2:35 PM, Certified Nursing Assistants (CNA B and I) were interviewed about the facility's infection control practices when providing care to residents on droplet isolation precautions. CNA I was observed wearing a KN-95 mask and CNA B was observed to be wearing a KN-95 mask with an external respirator valve. Both staff reported the masks were provided by the facility. When asked about what specific PPE was worn to provide care to residents on droplet isolation precautions, one staff responded, A mask and gown. The other staff reported, A mask, gown, footwear and gloves. When asked if they had been educated on or provided access to protective eyewear such as goggles, glasses, or faceshields, both reported No. On 9/22/20 from approximately 8:30 AM until 11:00 AM observations of the facility staff revealed all staff except for therapy were not wearing protective eyewear coverings such as goggles, glasses, or faceshields when entering the rooms of residents on droplet isolation precautions to provide care. Additionally, the only masks worn by nursing staff were KN-95 masks (some which had a respirator valve). There were no observations of any staff utilizing

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 14) actual N-95 masks for residents on droplet isolation precautions. According to Centers for Disease Control (CDC) guidance as of 8/27/20, .DO NOT choose masks that have exhalation valves or vents, which allow virus particles to escape . On 9/22/20 at 10:55 AM, when queried about the facility's availability of N-95 masks and whether there were any concerns with obtaining for staff use, the DON reported, We have in carts. At beginning of COVID in March had difficulty getting but have them now. The DON was requested to observe the facility's supply. At approximately 11:00 AM, observation of the medication/treatment carts revealed no available N-95 masks. The DON further reported the supply used to be kept in the beauty shop and upon observation revealed there was no longer any PPE stored in the beauty shop. The DON proceeded to access her office and pulled a supply of KN-95 masks and reported, Thee are all the N-95's. Oh, those are K-95's. When asked if there were only KN-95 masks available, the DON proceeded to talk with the Administrator who reported the rest of the PPE supply was stored on another floor of the hospital and would obtain the N-95 supply. At approximately 11:10 AM, the Administrator and DON were asked about the PPE supplies and how staff would obtain if Administration staff were not available such as on weekends or evening shift. The Administrator reported she provided staff with a pack of masks (KN-95) that each contained five masks. When asked about the postings on the doors of residents on isolation, if that was acceptable, the DON reported, Signage was provided by the hospital. The DON was queried if the current signage met current CDC guidance for COVID-19 practices in the nursing home and reported she would follow up. (At approximately 2:00 PM, the DON acknowledged the current signage was incorrect and that the facility had removed and placed new signage, which indicated eyewear was to be worn.) At approximately 11:20 AM, the DON reported the N-95 masks were stored in her office. When asked why these masks were not made available to staff that provided care to residents on droplet isolation precautions as recommended by the CDC, the DON reported, I have to start (making them available to staff). On 9/22/20 at 11:30 am, observations included rooms occupied by R120 and R121 who were identified as residents on droplet isolation precautions due to recent admission into the facility. There were PPE carts placed outside the room which contained gloves, gowns, and protective eyewear (glasses). There were signs posted on both doors that read, DROPLET PRECAUTIONS (in addition to Standard Precautions) .Personal Protective Equipment (PPE) Don a mask upon entry into the patient room or cubicle .Limit transport and movement of patients to medically-necessary purposes. If transport or movement in any healthcare setting is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette. No mask is required for persons transporting patients on Droplet Precautions. Resident #120: R120 was admitted into the facility on [DATE], discharged on [DATE], and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident 121: R121 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. On 9/23/20 at 9:23 AM, an interview and record review was completed with the DON regarding surgical care for R121. During this time, the DON was observed to repeatedly touch the face mask (N-95) and pull down the face mask to the chin area to talk. The DON was requested to place the facemask back in place and reported It's just so hot with this on. Resident #18: On 9/22/20 at 11:43 am, a medication administration observation of Licensed Practical Nurse (LPN) X administering medications was completed. LPN X was observed to have entered R#18's room, obtained their left hand, second digit for a blood sugar reading. After the reading was obtained, LPN X was observed to have thrown the lancet (which contained the resident's blood) into the resident's bedside garbage. Once out of the room and back to the medication cart the nurse was queried on the disposal of the dirty lancet into the resident's bedside garbage and LPN X confirmed that they disposed of it in the residents bedside garbage. The Director of Nursing (DON) was queried on the facility's protocol of the disposal of a lancet containing blood on it and stated that it should be disposed of in the sharps container. A facility policy titled Obtaining a Fingerstick Glucose Level revised 9/22/20, documented in part .Obtain a blood sample by using a sterile lancet .Dispose of the lancet in the sharps disposal container . Resident #9: On 9/23/20 at 8:08 am, a medication administration observation of LPN F administering medication was conducted. After obtaining a blood sugar reading on R#9, LPN F returned and placed the glucometer on the top of their medication cart, without disinfecting it. At 8:20 am, LPN F picked the dirty glucometer up and placed it back in their cart. At this time LPN F confirmed that all of the residents' blood sugars were completed for the morning. A facility policy titled Obtaining a Fingerstick Glucose Level revised 9/22/20, documented in part . Clean and disinfect reusable equipment between uses . On 9/23/20 at 2:39 pm, the DON was queried on the above observation of LPN F not disinfecting a glucose monitor after use and stated in part .they should wipe them off after every use . Resident #171: R#171 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. On 9/22/20 at 12:09 pm, an interview was conducted with R#171, who resided in a droplet precaution room. The resident was placed on droplet precautions, as a newly admitted resident per the CDC's guidance for the monitoring of newly admitted residents. At 12:21pm, the surveyor observed no receptacle to dispose of dirty Personal Protective Equipment (PPE) by the resident's room door. R#171 was asked where the staff dispose of their gowns and the resident stated in part .I don't know, but there is some in my garbage right here . while pointing to their bedside garbage can. The surveyor proceeded to the resident's bathroom room to doff all PPE and wash their hands. On 9/23/20 at 4:01 pm, an additional interview was conducted with R#171 (who resided in a droplet precaution room). At 4:03 pm, LPN F entered into the room in full PPE to hang an Intravenous (IV) bag of antibiotics. After speaking to the resident, LPN F was observed exiting the room with their gown and gloves balled up in their hands. LPN F was stopped after a few feet from the door and asked where they were going to dispose of their dirty PPE. At that time LPN F re-entered R#171's room, with the dirty PPE still balled up in their hands and went into the resident's bathroom to dispose of their PPE in the resident's bathroom garbage can. LPN F then stated there was a garbage can here inside of the room. I don't know what happened to it. On 9/23/20 at 4:12 pm, the Director of Nursing was queried on when and where staff should doff of PPE when leaving R#171's room and stated that staff should take off their PPE before walking out of the room, into a garbage bag located by the door. At that time, a PPE, infection control and droplet precaution policy was requested from the DON. A facility policy titled Personal Protective Equipment (revised 9/23/20) was reviewed and contained no guidance for staff on when and where to doff of PPE. A facility policy titled Categories of Transmission-Based Precautions (revised 3/26/20) was reviewed and contained no guidance for staff on when and where to doff of PPE. A facility policy titled COVID-19 PROTOCOL (revision date of 5/5/20) documented in part .Procedure for PUI or Confirmed Positive COVID-19 Resident in Facility .staff working on COVID-19 recovery units must adhere to appropriate donning/doffing of PPE to avoid cross contamination . The facility failed to instruct staff on when and where to dispose of PPE while caring for new or re-admissions.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observation, interview, and record review the facility failed to maintain an effective pest management program, resulting in the presence of live pests in the facility. This deficient practice has the potential to affect all 17 residents in the facility. Findings include: On 9/22/20 at approximately 1:00 PM and 9/23/20 at 8:47 AM, the room occupied by R2 and R12 was observed to have several large black flying insects throughout the room. The residents were observed to be swatting at the insects multiple times. When asked if that had been a new or ongoing issue, one of the residents reported, Been a while. On 9/24/20 at 9:50 AM Dietary & Housekeeping Manager (Staff J) was asked who monitored the facility's pest control. At that time, Staff J reported a contracted pest control company came every month and there had been ongoing issues with gnats and flies. Staff J further reported, If it's like in (name of R2) room we keep wiping down with bleach wipes. Staff J was asked to accompany to observe the room occupied by R2 and R12 and requested to also bring Housekeeper (Staff K) as he was currently the only housekeeper on staff. On 9/24/20 at 9:53 AM, Staff J and Staff K observed the room and confirmed multiple large black flying insects were present throughout the room. Staff J was requested to provide pest control logs and reported the Administrator would have those. On 9/24/20 at approximately 10:15 AM, the Administrator was requested to provide the facility's pest control logs and results from visits since last recertification survey. At that time, the Administrator reported there was no actual log, but would continue to look. A review of the documentation provided by the Administrator included a service proposal dated 7/13/20 and three invoice documents dated 7/14/20, 8/1/20 and 8/17/20. A review of the 7/13/20 service proposal documented, .Monthly pest control for gnats, foam drains as needed . A review of the 7/14/20 and 8/17/20 invoices documented, in part: Contract Pest Control for JUL (July) 2020 and Contract Pest Control for AUG (August) 2020. There were no details included as to what pest activity had been identified (if any) or recommendations. A review of the 8/1/20 Issue Date invoice was difficult to read but did document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235703	A. BUILDING _____ B. WING _____	**09/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND MANOR NURSING & REHAB CENTER LLC	**50 N PERRY ST, 1ST FOOR PONTIAC, MI 48342**

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 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 15) .Add hot spot for flys <sic>. This invoice was signed on the 8/17/20. On 9/24/20 at approximately 4:00 PM, the Administrator was informed of the above observations and reported she was not aware of that concern but would follow up. A request for any other documentation was made but there was no further documentation provided by the end of the survey. A review of the facility's Pest Control policy dated Reviewed 9/23/20 documented, in part: .This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .