STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLAREN LAPEER REGION	1375 N MAIN ST LAPEER, MI 48446

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review, the facility 1) Failed to operationalize abuse policies for the screening of an employee providing direct care to residents and 2) Failed to operationalize a fingerprint-based criminal history record check, for one Certified Nursing Assistant (CNA F) of six employees reviewed for background checks, resulting in the potential employment of staff with a criminal background or history of abuse and the potential of residents not being protected from abusive individuals. Findings include: On 3/11/20 at 4:17 PM, during a review, of sufficient and competent nurse staffing, an interview was conducted, with the Regional Director of Labor and Employee Relations S and Human Resource Consultant G, regarding background checks for selected employees. A review, of Certified Nursing Assistant (CNA) F's background checks, revealed the fingerprinting-based criminal history record was not available in the Staff's personnel file. Human Resource Consultant reported CNA F's hire date was 8/5/19. When queried why the staff did not have the fingerprinting completed, the Human Resource Consultant indicated that audits were completed and they were not able to locate the fingerprinting and stated, She has been contacted and she is not responding. When queried when she had been contacted, the Human Resource Consultant reported the CNA had been contacted the middle of last week. A review, of the document Employee Schedule-Weekly, received at the start of the survey, revealed CNA F was scheduled to work on Sunday 3/8/20, Monday [DATE] and Tuesday 3/10/20. A review, of the correspondence, from Human Resource Consultant G, that was reported as sent to CNA F, revealed the fingerprinting was needed to comply with various regulations, gave instructions regarding the application to schedule an appointment and indicated it was imperative the fingerprinting be completed and gave a due date on (NAME)18, 2020. The correspondence gave contact information regarding questions. A review of the document provided by the facility titled, Michigan Workforce Background Check Consent and Disclosure, revealed, MCL 333XXX a, MCL 330.1134a, and MCL 440.734b require that a health facility/agency that is a: .nursing home, hospital that provides swing bed services, home for the aged .Shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency or AFC (adult foster care) until the health facility/agency or AFC conducts a fingerprint-based criminal history check . Health Facility or Agency .The health facility/agency or AFC: . d. Must retain verification of compliance with background check requirements .
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement baseline care plans to guide the care provided to 6 residents (Resident #2, Resident #60, Resident #61, Resident #64, Resident #110, and Resident #111) of 9 residents reviewed for baseline care plans, resulting in the failure to provide instructions to the staff for effective and person centered care to promote well-being and provide wound care, prevent skin breakdown, provide post-[MEDICAL TREATMENT] care, manage constipation and provide pain management. Findings Include: Resident #60: During the initial tour of the facility on [DATE] at 11:30 AM, Resident #60 was observed lying in bed visiting with her husband. She said she had fallen at home and fractured her left ankle. Resident #60 said she had pain and stated, Oh, don't touch my ankle; then it will hurt. The resident was asked if she received help from the staff for care and said she needed 2 people to help her to the bathroom. The resident said she was waiting for swelling to decrease on her ankle so that she could have surgery to repair the break. On 03/09/20 at 11:54 AM, Resident #60's husband said he had received a list of (Resident #60's) medications, but no one had yet talked to him about her plan of care. A review of the resident's medical record indicated the resident was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The Minimum Data Set (MDS) assessment was not yet completed to aid in identifying the resident's cognitive abilities or care needs. A review of the Resident's Baseline Care Plan revealed it was provided/reviewed with the resident/family on 3/10/20 by Nurse K, Copy of care plan reviewed and left with the patient. The Baseline Care Plan was reviewed and provided to Resident #60 >48 hours post admission. Resident #61: On 3/09/20 at 1:48 PM, during a tour of the facility, Resident #61 was observed sitting on the edge of her bed watching television. The resident said she was admitted to the facility after falling at home and fracturing her right leg. The resident said she had a blister on top of her right foot; stating, At first they thought I was allergic to something. I asked if it was normal. The nurse said don't worry about it. A review of Resident #61's medical record, revealed she was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 indicating full cognitive abilities and needed 1-person assistance with care. An interview and review of physician orders with the Director of Nursing (DON) on 3/11/20 at 2:45 PM, indicated Resident #61 was seen by a wound care doctor and wound nurse on 2/21/20 Per consult for the large blister on her right foot. There was no documentation in the medical record to indicate who or when the wound was identified. A review of the resident's Baseline Care Plan dated completed on 2/22/20 by Nurse D and Copy of EMAR (reference to the Baseline Care Plan) provided to resident, by the same nurse. There was no mention of the blister on the resident's right foot. The Baseline Care Plan was provided to the resident >48 hours after admission. Resident #64: On 3/09/20 at 2:03 PM during the initial tour, Resident #64 was observed lying in bed talking with family. The resident said he was at the facility because he had surgery on his left shoulder. When asked if the Resident or family had received information about the resident's Baseline Care Plan, they said they were unsure. A review of Resident #64's medical record, indicated the resident was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment dated [DATE] revealed the resident had a BIMS score of 6/15 indicating severe cognitive decline and needed assistance with all care. A review of the Baseline Care Plan for Resident #64 indicated it was completed on 2/23/20 by Nurse K. On 2/23/20 Nurse C documented Reviewed care plan and medication sheet with Resident's representative. This was greater than 48 hours after admission. On 3/10/20 at 2:30 PM, during an interview with Nurse B, she said the Staff Nurses were supposed to complete the Baseline Care Plan and present it to the Resident or responsible person. A review of a facility document titled, Baseline Care Plan Completion Date and Time, dated 4/8/19 revealed, . the Baseline Care Plan Must be signed as completed within 48 hours . Review the Baseline Care Plan for all of your residents ensuring they are complete, sign . There was no direction to provide the Baseline Care Plan information to the Resident or responsible party. Resident #2: A review of Resident #2's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed the Resident was cognitively intact and needed limited assistance of one-person physical assist with bed mobility, transfer, dressing, toilet use and personal hygiene. Further review of the medical record revealed the resident went out of the facility to the adjoining hospital for [MEDICAL

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLAREN LAPEER REGION	1375 N MAIN ST LAPEER, MI 48446

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) TREATMENT] treatments. On [DATE], at 3:43 PM, an observation was made of Resident #2 lying in bed. The Resident was interviewed regarding their care they received at the facility. The Resident indicated he went to [MEDICAL TREATMENT] treatments at the hospital. When queried if staff take his vital signs when he returns from [MEDICAL TREATMENT]. The Resident stated, Usually they check me when I come back but not always. Sometimes I have issues with my blood pressure (BP) going down and they won't let me leave until it is ok, and explained they take his blood pressure where he gets the [MEDICAL TREATMENT] treatments done. The Resident showed his right arm where he had an arteriovenous fistula (a connection or passageway between an artery and a vein for the use during [MEDICAL TREATMENT] treatments). A review of Resident #2's baseline care plans revealed Resident was admitted into the facility on [DATE] at 4:53 PM. The document titled, Baseline Care Plan, was documented as completed on 1/23/20 at 11:00 PM. More then 48 hours after admission. The date reviewed with resident/representative was 2/23/20. The Baseline Care Plan did not give directive regarding not completing blood pressure monitoring on the Resident's arm where an AV (arteriovenous) fistula was for [MEDICAL TREATMENT] treatments. A review, of Resident #2's Baseline Care Plan, Kardex (a guide used by staff of care guidelines) and the comprehensive care plan documents, with Nurse Supervisor A, was conducted on 3/10/20 at 3:29 PM. The Nurse Supervisor indicated the directive for the blood pressure not to be taken on the Resident's right arms was to be on the care plans and Kardex. Resident #110: On [DATE] at 1:52 PM, an observation was made on the initial tour of the facility of Resident #110 not in their room. Nurse B was queried regarding the whereabouts of Resident #110. The Nurse reported the Resident had pain in their abdomen, a cat scan was done, and they were taken for emergency surgery and left at 12:10 PM. A review of Resident #100's medical record, revealed an admission into the facility on [DATE] with a [DIAGNOSES REDACTED]. The Resident's discharge plan goal was to return home with his wife. A review of Resident #100's Baseline Care Plan, revealed the Resident was prescribed [MEDICATION NAME] 5-325 mg (narcotic pain medication). The care plan did not include directive for a care plan regarding pain. The Baseline care plan had an admitted on 3/6/20 at 4:02 PM and the completed date on [DATE] at 10:25. The care plan was not documented as reviewed with resident or representative or that a list of medication was provided to the resident or representative. Resident #111: On [DATE] at 2:35 PM, an interview was conducted with Resident #111 on the initial tour of the facility. The Resident expressed had had come into the facility with constipation issues and was concerned about going days without a bowel movement and was feeling uncomfortable. The Resident was queried regarding pain and reported issues with pain in his neck and bottom and was taking [MEDICATION NAME] and a muscle relaxant. A review of Resident #111's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. The History and Physical Note, dated 3/8/20 at 11:40 AM, revealed, . (Resident #111) is sitting up in the chair and states he has pain on his bottom from a bed sore . A review, of Resident #111's Baseline Care Plan, revealed an admitted on 3/7/20 at 5:30 PM, baseline care plan completed on [DATE] at 10:20 AM and was not reviewed with the resident/representative and did not include a signature of the Resident or Representative as receiving the care plan. The Baseline Care Pan listed the [MEDICATION NAME] for pharmacological pain regimen for the presence of pain in the neck but did not list a focus, goals or interventions for a care plan regarding pain. The care plan did not list constipation as a concern with goals or interventions on the baseline care plan. On 3/10/20 at 1:59 PM, a review of Resident #111's baseline care plan was conducted with the Nurse Supervisor A and MDS Nurse B. The Nurse Supervisor was queried regarding pain as an issue for Resident #111 upon admission and the baseline care plan. The Nurse Supervisor after review of the care plan stated, I am surprised they don't have a pain care plan, on the fill in Baseline Care Plan document. The Nurse Supervisor reported the [MEDICATION NAME] was listed under the medication care plan and that was the only indication of pain being addressed. Nurse B indicated the nurses start the baseline care plan and would be adding issues that the Residents come with on admission into the care plan and can record under #14 other conditions. Nurse B confirmed that upon admission the nurse can add issues to the baseline care plan. The Nurse Supervisor agreed that the issues of constipation and pain should be found on the baseline care plan. Nurse B reported that the baseline care plans had been streamlined and condensed but certain issues such as pain was no longer incorporated into the baseline care plan. A review of the facility policy titled, Baseline Care Plan Policy, effective date on 4/2019, revealed, . completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission . The admitting nurse will complete the Baseline Care Plan using admitting documentation, Admitting Nursing Assessment, and resident interview . The admitting nurse will review admitting information, conduct all admitting assessments, and interview the resident of resident's representative at the time of admission to collect information prior to formulating the Baseline Care Plan . When the Baseline Care Plan is completed the nurse completing the care plan will document the completion by signing with the date and time of completion. Completion date and time must be less than 48 hours after the admitted and time . The resident will be provided a copy of The Baseline Care Plan with a medication list. The completed care plan is provided to ensure the resident has a complete understanding of the plan of care. The Social Worker and or Nurse will review the care plan with the resident as soon as practical after the Baseline Care Plan is completed. The Resident review of the care plan will be documented by signatures of the Social Worker or Nurse and resident or representative on the care plan form and in the resident progress notes .
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 interview and record review the facility failed to develop and implement comprehensive care plans for two residents (Resident #2 and Resident #61) of nine residents reviewed, resulting in Resident #2 lacking a care plan to address post-[MEDICAL TREATMENT] care and a wound on the left foot and Resident #61 not having a care plan for a large pressure ulcer on her right foot. Findings Include: Resident #61: On 3/09/20 at 1:48 PM, during a tour of the facility, Resident #61 was observed sitting on the edge of her bed watching television. The resident said she was admitted to the facility after falling at home and fracturing her right leg. The resident said she had a blister on top of her right foot; stating, At first they thought I was allergic to something. I asked if it was normal. The nurse said don't worry about it. A review of Resident #61's medical record, revealed she was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 indicating full cognitive abilities and needed 1-person assistance with care. An interview and review of physician orders [REDACTED].#61 was seen by a wound care doctor and wound nurse on 2/21/20 Per consult for the large blister on her right foot. There was no documentation in the medical record to indicate who or when the wound was identified, the size or description. A review of the Skin Assessments for Resident #61 revealed the following: 2/18/20 at 10:15 PM- Right heel . Stage 1 (pressure ulcer) . Non-blanching, boggy heel, Red. 2/22/20 at 8:50 AM- Popped blister on top aspect of right foot . some scant drainage. A Progress Note, dated 2/21/20 at 8:31 AM, revealed In room (with wound physician) for a new consult. Blister noted on the right dorsal foot that measured 8 cm x 3.5 cm . (physician) drained at bedside. We applied 4 x 4' s' and wrapped the leg with kerlix and coban from the toes to the knee. [MEDICATION NAME] G was placed over the knee . A review of a Progress Note, dated [DATE] at 8:00 AM, Wound care here today . resident is not to wear Prevalon Boot. A review of a Progress Note, dated A review of a Progress Note, dated 3/2/20 at 6:41 AM, Resident complained of pain in right lower leg, and suspected her wraps were on too tight. Her foot was red and swollen. Removed heel protector and ace bandage and immediately color improved and swelling decreased . A review of a Progress Note, dated . observed (patient's right lower extremity) with heel bow donned on 3/4/20. Patient with increased [MEDICAL CONDITION] to forefoot and toes with complaints of discomfort . A review of the resident's Care Plan's revealed the following: Pressure Ulcer, Resident is at risk for pressure ulcer due to impaired sensory perception, start date 2/20/20 with Goal- Intact skin without evidence of redness, irritation, maceration, or open areas, with Interventions: 2/21/20 Wound care to apply [MEDICATION NAME], hydrogel, optical to right foot and wrap with kerlix and coban . per the Wound care physician, and 2/20/20 Elevate heels and use protectors-boot. There was no mention of the type of wound or location on the foot. The Goal was not modified to include reddened heels on admission or the blister on the dorsal aspect of the right foot. The Care Plan did not provide guidance on use of a heel boot or heel protectors or how to wrap the resident's right foot to aid in preventing, redness, swelling, pain and the potential for decreased wound healing or new wounds. Nutritional Status, Alteration Nutrition Status related to: s/p fall with tibia and fibula fracture, start date 2/26/20. There was no mention of pressure ulcers or interventions to promote healing of the wounds. ADL Function, Resident has surgical wound related to tib-fib fracture,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLAREN LAPEER REGION	1375 N MAIN ST LAPEER, MI 48446

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) start date 2/20/20, Goal: Resident's surgical wound will heal without complications, with Interventions: 2/20/20, Assess condition of surrounding skin. Report emergence of skin excoriation. There was no intervention addressing the resident's blister on her right foot. Resident #2: A review of Resident #2's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed the Resident was cognitively intact and needed limited assistance of one-person physical assist with bed mobility, transfer, dressing, toilet use and personal hygiene. Further review of the medical record revealed the resident went out of the facility to the adjoining hospital for [MEDICAL TREATMENT] treatments. On [DATE], at 3:43 PM, an observation was made of Resident #2 lying in bed. The Resident was interviewed regarding their care they received at the facility. The Resident indicated he went to [MEDICAL TREATMENT] treatments at the hospital. When queried if staff take his vital signs when he returns from [MEDICAL TREATMENT]. The Resident stated, Usually they check me when I come back but not always. Sometimes I have issues with my blood pressure (BP) going down and they won't let me leave until it is ok, and explained they take his blood pressure where he gets the [MEDICAL TREATMENT] treatments done. The Resident showed his right arm where he had an arteriovenous fistula (a connection or passageway between an artery and a vein for the use during [MEDICAL TREATMENT] treatments). The Resident indicated he had sores on his legs where they had started to bleed and was getting ointment to one leg and a dressing to the other leg. The Resident indicated he was unsure how the bleeding had started. On 3/10/20 at 3:29 PM, an interview was conducted with the Nurse Supervisor A of the care plans for Resident #2. The care plan binder was reviewed, and the baseline care plan was present, but the comprehensive care plan was not in the book where cares plans were kept for staff to reference and located at the nurses station. The Nurse Supervisor went to get the comprehensive care plans and returned to continue the review of care planning for Resident #2. A review of the care plan with the Nurse Supervisor revealed a lack of a care plan for skin integrity regarding the wound on the Resident's legs. The care plan listed a care plan in the category of Pain, Resident requires [MEDICAL TREATMENT], with a goal of Resident will not exhibit signs or symptoms of infection at access site. The approach listed, Monitor and report signs of localized infection . and Monitor and report signs of systemic infection . The Nurse Supervisor indicated the care plan was identified wrong in the category and lacked directive to care for staff regarding [MEDICAL TREATMENT] care.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that pressure ulcers were assessed, monitored and that wound care was provided for one resident (Resident #61) of three residents reviewed for pressure ulcers, resulting in Resident #61 lacking appropriate assessment, monitoring and treatment for [REDACTED]. Findings Include: Resident #61: On 3/09/20 at 1:48 PM, during a tour of the facility, Resident #61 was observed sitting on the edge of her bed watching television. The resident said she was admitted to the facility after falling at home and fracturing her right leg. The resident said she had a blister on top of her right foot; stating, At first they thought I was allergic to something. I asked if it was normal. The nurse said don't worry about it. A review of a Psychology Consult Note dated [DATE] revealed, The patient was a good historian and was able to describe the circumstances leading to her hospitalization . A review of Resident #61's medical record, revealed she was admitted to the facility on [DATE] with Diagnoses: [REDACTED]. The MDS assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 indicating full cognitive abilities and needed 1-person assistance with care. A review of physician orders and interview with the Director of Nursing (DON) on 3/11/20 at 2:45 PM, indicated Resident #61 was seen by a wound care doctor and wound nurse on 2/21/20 Per consult for the large blister on her right foot. There was no documentation in the medical record to indicate who found the wound or when the wound was identified, the size or description. The Nursing Admission Assessment identified Right Heel, 3 x 3 (cm) Stage 1, non-blanching, boggy, heel. Red. A review of the documents with the DON revealed a lack of daily wound assessment, wound care and appropriate treatments were enacted to promote healing of the right anterior/dorsal foot and right heel wounds. A review of the Skin Assessments for Resident #61 identified the wounds were not assessed daily and the dressings were not changed daily as ordered. A Right heel wound was identified on admission 2/18/20 and documentation was missing for the wound on multiple occasions: From 2/18/20-[DATE], It was only documented on 2/18/20, 2/19/20 2/29/20, 3/1/20, 3/4/20 and 3/5/20. There was a lack of assessment, identified wound care, and consistent treatment and preventive measures. There was no ordered treatment for [REDACTED]. Stage 1 (pressure ulcer) . Non-blanching, boggy heel, Red. 2/29/20 at 10:00 AM- Right Heel, Non-blanching, darkened, [DIAGNOSES REDACTED] . covered with kerlix while covering right foot wound and elevated heel off bed . 2/29/20 at 3:56 PM- Right heel, intact, [DIAGNOSES REDACTED], darkened, applied heel protector and elevated heels. 3/1/20 at 10:00 AM- . Right heel, is not blanching, [DIAGNOSES REDACTED], elevation of bilateral heels and heel protectors. 3/4/20 at 10:29 AM- Right heel, intact [DIAGNOSES REDACTED] 3/5/20 at 8:15 PM- Right heel ulcer, [DIAGNOSES REDACTED], [MEDICAL CONDITION] . 3/5/20 at 11:53 AM, a Progress Note, Patient observed right lower extremity with heel bow donned on 3/4/20. Patient with increased [MEDICAL CONDITION] to forefoot and toes with complaints of discomfort. Not recommending heel bow secondary to tightness . A right foot blister (top of foot) was first documented 2/21/20 by the Wound Care physician and nurse. A physician order was created on 2/20/20 at 2:52 PM- Consult Wound Care. There was no assessment of the area on 2/20/20 to indicate why the Wound Care Physician was contacted. Resident #61 had a lack of wound assessment for the right foot on 2/27/20, 2/28/20 and 3/1/20. Between 3/1/20 and 3/6/20 the resident developed black tissue on the wound. A Progress Note, dated 2/21/20 at 8:31 AM, revealed In room (with wound physician) for a new consult. Blister noted on the right dorsal foot that measured 8 cm x 3.5 cm . (physician) drained at bedside. We applied 4 x 4' s' and wrapped the leg with kerlix and coban from the toes to the knee. [MEDICATION NAME] G was placed over the knee . A Physician Consult Note dated 2/21/20 at 12:01 PM, created by Wound Care Physician N provided, .She states she did have an Ace wrap on the right lower leg but complained of discomfort and this was removed to reveal evidence of a large blister to the anterior distal lower right leg . Large serous blisters are noted to the dorsal right lower leg and ankle measuring 8 x 3.5 cm . (incision and draining) of the blister was performed with drainage of serous fluid . dressing change daily by nursing . A Skin assessment dated [DATE] at 8:50 AM- Popped blister on top aspect of right foot . some scant drainage. A review of a Progress Note, dated [DATE] at 8:00 AM, Wound care here today . resident is not to wear Prevalon Boot. A review of a Progress Note, dated 3/2/20 at 6:41 AM, Resident complained of pain in right lower leg, and suspected her wraps were on too tight. Her foot was red and swollen. Removed heel protector and ace bandage and immediately color improved and swelling decreased . A review of a Progress Note, dated . observed (patient's right lower extremity) with heel bow donned on 3/4/20. Patient with increased [MEDICAL CONDITION] to forefoot and toes with complaints of discomfort . A Wound Care Evaluation, by Physician N on 3/6/20 provided, Right anterior ankle measures 7 x 3 with eschar . area is beginning to lift off around the margins . Right heel pressure ulcer measures 3 x 4 (cm) with black stable eschar (dead tissue) . dressing with alginate, hydrogel, nonadherent, Kerlix and a [MEDICATION NAME] F to the right lower extremity. Dressing on a daily basis . A Physician Note dated 3/10/20 written by Physician L revealed, . Her right ankle and foot is dressed . She will also follow with the wound clinic for her left ankle ulcer . The resident was discharged to home on 3/10/20 with little documentation of the right heel pressure ulcer and treatment. The right foot blister had deteriorated to develop necrotic tissue and the resident needed to continue to receive care from a Wound Clinic on discharge. A review of the physician orders revealed the following: 2/18/20- Dressing Change per Protocol, Change dressing as needed, abd, kerlix and wrap with ace wrap (to surgical incision right ankle). 2/20/20- Consult Wound Care. 2/21/20- Dressing Wound, Apply 4 x 4' s' over the right foot blister and wrap with kerlix/coban from toes to knee. Place [MEDICATION NAME] G over the knee area. Change daily. 3/6/20- Dressing- Wound, Apply hydrogel, opticell, 4 x 4 and kerlix to the right dorsal foot wound. Place [MEDICATION NAME] F on right leg from toes to knee. There were no orders for the right heel pressure ulcer. A review of the resident's Care Plan's revealed the following: Pressure Ulcer, Resident is at risk for pressure ulcer due to impaired sensory perception, start date 2/20/20 with Goal- Intact skin without evidence of redness, irritation, maceration, or open areas, with Interventions: 2/21/20 Wound care to apply [MEDICATION NAME], hydrogel, optical to right foot and wrap with kerlix and coban . per the Wound care physician, and 2/20/20 Elevate heels and use protectors-boot. There was no mention of the type of wound or location on the foot. The Goal was not modified to include reddened heels on admission or the blister on the dorsal aspect of the right foot. The Care Plan did not provide guidance on use of a heel boot or heel protectors or how to wrap the resident's right foot to aid in preventing, redness, swelling, pain and the potential for decreased wound healing or new wounds. Nutritional Status, Alteration n Nutrition Status related to: s/p fall with tibia and fibula fracture, start date,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLAREN LAPEER REGION	1375 N MAIN ST LAPEER, MI 48446

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) 2/26/20. There was no mention of pressure ulcers or interventions to promote healing of the wounds. ADL Function, Resident has surgical wound related to tib-fib fracture, start date 2/20/20, Goal: Resident's surgical wound will heal without complications, with Interventions: 2/20/20, Assess condition of surrounding skin. Report emergence of skin excoriation. There was no intervention addressing the resident's blister on her right foot. A review of the Weekly Team Care Conferences, for Resident #61, dated 3/5/20 revealed, Wounds/Dressings: Right leg/foot wounds healing without complications, but the wounds had consistently declined since admission, needing debridement (right foot) and continued care from the Wound Clinic on discharge. A review of the facility policy titled, Management of Wound & Hyperbaric Services, dated revised on November 2016, provided Purpose: To identify patients at risk for pressure ulcers and intervene to maintain skin integrity and to prevent tissue breakdown . Perform a head to toe assessment at least every shift, especially checking pressure points . Consult dietary on all at risk patients . encourage protein intake as appropriate . Instruct patient and family regarding pressure ulcer etiology, preventive skin care and the role of adequate nutrition in skin health and wound healing.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that assessments were completed timely (upon the resident's return to the facility after [MEDICAL TREATMENT] treatments) for one resident (Resident #2) of one resident reviewed for [MEDICAL TREATMENT] care, resulting in the potential for complications from post [MEDICAL TREATMENT] treatments to go unrecognized and untreated. Findings include: Resident #2: A review of Resident #2's medical record, revealed an admission into the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set assessment revealed the Resident was cognitively intact and needed limited assistance of one-person physical assist with bed mobility, transfer, dressing, toilet use and personal hygiene. Further review of the medical record revealed the resident went out of the facility to the adjoining hospital for [MEDICAL TREATMENT] treatments. On [DATE], at 3:43 PM, an observation was made of Resident #2 lying in bed. The Resident was interviewed regarding their care they received at the facility. The Resident indicated he went to [MEDICAL TREATMENT] treatments at the hospital. When queried if staff take his vital signs when he returns from [MEDICAL TREATMENT]. The Resident stated, Usually they check me when I come back but not always. Sometimes I have issues with my blood pressure (BP) going down and they won't let me leave until it is ok, and explained they take his blood pressure where he gets the [MEDICAL TREATMENT] treatments done. The Resident showed his right arm where he had an arteriovenous fistula (a connection or passageway between an artery and a vein for the use during [MEDICAL TREATMENT] treatments). A review, of the documents in the paper medical record, of the Transitional Care Unit [MEDICAL TREATMENT] Communication Records, from 1/23/20 to 3/10/20, revealed the following: -Dated 1/28/20, no recorded pre or post [MEDICAL TREATMENT] treatment weights, comment revealed, Bleeding around venous needle . Bp recorded by [MEDICAL TREATMENT] unit was 110/54. -Dated 1/30/20, no recorded pre-[MEDICAL TREATMENT] treatment weights. Bp recorded by the [MEDICAL TREATMENT] unit was 96/47. -Dated [DATE], no recorded pre-[MEDICAL TREATMENT] treatment weight. Bp recorded by the [MEDICAL TREATMENT] unit was 98/54. Notes from [MEDICAL TREATMENT] unit revealed, prolonged bleeding . -Dated 2/22/20, no recorded pre-[MEDICAL TREATMENT] treatment weight. A review, of Resident #2's progress notes, dated [DATE] at 1:08 PM, revealed, Received a call from outpatient [MEDICAL TREATMENT] stating that they where finally able to send PT (patient) back at 12 pm. Pt has uncontrolled bleeding from right arm AV fistula site and it took them 1 hour to get the bleeding under control. PT has pressure dressing to site . A review, of Resident #2's vital signs for post-[MEDICAL TREATMENT] assessment and progress notes revealed vital signs documented later in the day between 5:30 PM and 7:00 PM. The Resident had [MEDICAL TREATMENT] treatments in the early morning with [MEDICAL TREATMENT] ending in the morning before noon. A random review of the vital signs taken at the facility after [MEDICAL TREATMENT] treatments included the following: -Date 1/23/20, [MEDICAL TREATMENT] ended at 11:13 AM, vitals documented at 5:34 PM. -Date 1/30/20, [MEDICAL TREATMENT] ended at 10:49 AM, vitals documented at 6:24 PM. -Date [DATE], [MEDICAL TREATMENT] ended at 10:58 AM, vitals documented at 6:13 PM. [MEDICAL TREATMENT] Communication record revealed the Resident had prolonged bleeding as documented by the [MEDICAL TREATMENT] unit. A review of the progress notes, dated [DATE] at 1:08 PM, revealed, Received a call from outpatient [MEDICAL TREATMENT] stating that they where finally able to send PT (patient) back at 12 pm. Pt has uncontrolled bleeding from right arm AV fistula site and it took them 1 hour to get the bleeding under control. PT has pressure dressing to site . Vital signs were not documented as assessed until 6:13 PM. -Date 2/13/20, [MEDICAL TREATMENT] ended at 10:32 AM, vitals documented at 6:37 PM. -Date 2/20/20, [MEDICAL TREATMENT] ended at 10:22 AM, vitals documented at 5:54 PM. -Date 2/22/20, [MEDICAL TREATMENT] ended at 10:20 AM, vitals documented at 5:28 PM. -Date 2/29/20, [MEDICAL TREATMENT] ended at 10:50 AM, vitals documented at 5:55 PM. -Date 3/5/20, [MEDICAL TREATMENT] ended at 10:12 AM. A review of the progress note, dated 3/5/20 at 12:23 PM, revealed, Pt (patient) during therapy BP dropped to 87/51 and c/o (complaints of) a headache. Scheduled Midodrin given. Rechecked BP 10 minutes later and it went up to 113/72. Pt stated that he was feeling better. Will cont. to monitor. On 3/10/20 at 2:26 PM, an interview was conducted, with the Nurse Supervisor A, regarding the communication with the [MEDICAL TREATMENT] center for Resident #2. The Nurse Supervisor reported that the pre-weight was completed by the Certified Nursing Assistant (CNA) when the Resident is taken to the [MEDICAL TREATMENT] unit and was to be recorded on the [MEDICAL TREATMENT] communication sheet and the post-weight was to be recorded after [MEDICAL TREATMENT] that the [MEDICAL TREATMENT] unit was to document in their communication with the post-[MEDICAL TREATMENT] vital signs. When queried when the Resident receives vital signs when returned back to the facility, the Nurse Supervisor stated, They are not done immediately after but before the shift ends. When queried when the Resident returns to the facility, the Nurse Supervisor reported the Resident returns usually about ten in the morning. When queried when the next set of vital signs are taken after the Resident returns after [MEDICAL TREATMENT] treatments, the Nurse Supervisor stated, About 5:30 (PM) in the evening, they get their vital signs at the end of shift, about 5:30 to 6:00 (PM). A review of the facility policy titled, [MEDICAL TREATMENT], effective date 1/2017, revealed, . 5. Patient Monitoring and Nursing Care: . g. Monitor the patient for complications associated with [MEDICAL TREATMENT] treatment to include: Muscle cramps, headache, nausea/vomiting, hypertension, coma, air embolism, [MEDICAL CONDITION], back pain and hypoxemia .

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly label medications and maintain sanitary medication storage of skin treatments (stored with oral and optical medications) for two of two medication carts reviewed for storage of medications and medical supplies, resulting in the potential for medications to lack therapeutic benefits and decreased efficacy and contamination of medication and treatment supplies. Findings include: On 3/11/20 at 10:41 AM, an observation was made with Nurse Supervisor A during the medication storage review, of the 36 -38 medication cart. The following observations were made: -A drawer with eye drops and skin treatments of triple antibiotic ointment, [MEDICATION NAME] cream and nasal spray stored together. All items were opened except for the nasal spray. The eye drops were in a bag. -Triple antibiotic ointment was opened and did not have a date of when it had been opened. -[MEDICATION NAME] cream was opened and did not have a date of when it had been opened. -[MEDICATION NAME] eye drops, brimondine eye drops and [MEDICATION NAME] acetate eye drops, opened but was not labeled with an open date. An observation was made with the Nurse Supervisor A and Nurse R of the 39-44 medication cart. An observation was made of a drawer for one Resident that had [MEDICATION NAME] cream with oral medications. Nurse R indicated that the [MEDICATION NAME] cream was for as needed use and had not been opened yet. The Nurse Supervisor reported they would get another drawer to store the cream from the oral medications. Another drawer for another resident revealed an opened [MEDICATION NAME] cream that did not have an open date and was stored with oral medications. On 3/11/20 at 1:57 PM, an interview was conducted with the Director of Nursing (DON) regarding the observations made of the medication storage review. The eye drops opened without a label of the date when opened and the standard of practice of eye drops not used after opened 28 days was reviewed with the DON. The DON indicated eye drops will have an open date and the expiration date if they are not good after 28 days. The topical medications stored with the eye drops and oral medications was reviewed with the DON. The DON indicated they should not be stored together and will inquire about a separate treatment cart. A review of the facility policy titled, Medication Storage Areas and Monthly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLAREN LAPEER REGION	1375 N MAIN ST LAPEER, MI 48446

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Pharmacy Inspections/Temperature Monitoring, with an effective date on 2/2020, revealed, . 5. All medication storage areas shall be inspected at least every month by personnel familiar with proper storage requirements with documentation that the following requirements are met: a. External products are separated from internal products. A review of the facility policy titled, Infection Control in TCU, with an effective date on 2/2019, revealed, . Resident care will be provided using current infection control guidelines . VIII. Reuse of resident care items . E. Tubes of ointment and bottles of medicated solutions will contain pt (patient) ID (identification), and will be discarded 30 days after opening or sooner if indicated .
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility 1) Failed to ensure that food products were properly labeled with an Opened on and Use by date and dispose of expired food items; 2) Failed to monitor temperatures of the refrigerated compartment of the coffee machines; 3) Failed to properly dry dishes before stacking/store and ensure cups were properly dried prior to prepping for use; 4) Failed to maintain sanitary storage of refrigerated meat items and the walk-in refrigerated area; and 5) Failed to monitor refrigerator temperatures containing food items brought in for residents and ensure that a freezer unit in a refrigerator used for residents' food was defrosted, resulting in the potential contamination of food, bacterial harborage and the increased potential for food borne illness. This deficient practice had the potential to affect all residents who consume food prepared in the kitchen or stored in the residents' refrigerator. Findings include: On [DATE] at 10:30 AM, an observation was made, during the initial tour of the kitchen, with the Director of Food Services (DFS) P. The following observations and interviews were made: -Vinegar with a received by date of [DATE], open date on [DATE] and an used date on [DATE]. The Director of Food Services was queried regarding how long stock stayed available in the facility and indicated they do not use past an expiration date. The vinegar had a lot number but no expiration date. When queried regarding keeping food over a year after received in the facility and what the policy was, the DFS reported they were unsure and will look up the policy. -Sweet rice seasoning, did not have a received by date and the item did not have an expiration date. The item was not open. -Multiple items were labeled with a date that used only a month and a day. When queried regarding not writing the year on the items and assured they have not been on the shelf for extended years especially for items that have a lot number and no expiration date, the DFS reported they do not use a year and they rotate stock so the older items get used first. -Red wine vinegar, received by date on ,[DATE], open date on ,[DATE], use by date on ,[DATE]. The DFS indicated that cooking wine was good for a year after opening. When queried that the red wine vinegar was not labeled correctly, the DFS stated, right. -Coffee Mate, received by date on ,[DATE], no manufactures expiration date. When queried regarding if the item came in this year [DATE] or [DATE], the DFS reported she could look it up on the invoice and stated, Ideally we would like them to (write the date with a year). -Large can of sliced black olives, received ,[DATE], no manufactures expiration date on the can. -Thicken Up, 2 cases, received by date on [DATE], expired [DATE]. The DFS expressed the item was expired and took it off the shelf. -Sweetened coconut flakes, opened bag, manufactures expiration date of [DATE], facility sticker indicated opened ,[DATE] (no year), use by date ,[DATE] (no year). Received by date of ,[DATE]. -Orange Marmalade, received on ,[DATE], no year, no manufactures expiration date on the jar. -Malt bottle, opened, no opened date, no use by date, manufactures expiration date on [DATE]. -Beef broth, came in on ,[DATE] (no year), 2 large boxes with a spout, opened, no opened date, no use by date on the boxes. The DFS indicated their old chef brought them in. There was not a manufactures expiration date on the boxes. -Powder lemonade drink mix, received date on [DATE], four packages. The DFS checked the package and did not see a manufactures expiration date and stated, It's been here over a year, and removed the drink mix from the storage shelf. The DFS then removed five packages of fruit punch drink mix that had a received date on [DATE]. -The walk in refrigerator was observed to have liquid on the floor and after questioning the Director, it was determined to be from a pan of cut potatoes that was overfilled and dripping from the wrap. The potato pan was above other food items. The other food items were covered but wet. -A bag of chicken thighs, raw, were on a metal pan that had dark red blood that looked like the blood was from a beef product. No beef was noted to be on the shelving above the chicken. When the DFS was queried, the DFS stated, It's blood of some sort, and indicated the raw chicken should not be on the pan with blood from a different meat source. -Beef patties in a bag that was in a box. The bag, of beef patties, was open and leaking onto a box on the shelf below that had pork patty mix that was wrapped in plastic. When queried regarding the leaking beef patties onto the box below, why a pan was not used, the DFS indicated it should be on a pan. The food prep area was reviewed with the Director of Food Services and the following observations were made: -Plastic food containers near a prep area, stacked, with food particles on the containers. The DFS was queried if the containers were ready to use, the DFS stated, yes. -Metal pans, stacked together, not dry. -Plastic mugs on a tray with plastic lids on them. The DFS indicated the cups were 'ready to serve.' A couple of the mugs were observed to be wet inside after removing the lids to check for moisture. -A review, of the coffee machine, revealed a compartment that was refrigerated. The DFS was asked about the temperature in the refrigerated compartment and reported she was unsure what the temperature was and indicated the temp was not monitored. Upon inspection of a carton of the liquid coffee that goes into the refrigerated compartment, the label indicated the coffee had a shelf life of 6 weeks at 41 degrees Fahrenheit. On [DATE] at 11:45 AM, an observation was made with the Director of Food Services of the dining area on the Transitional Care Unit. The coffee machine was similar to the one in the kitchen area and had a refrigerated unit were the concentrated coffee boxes were opened and positioned in the compartment. The DFS indicated the refrigerated compartment was not monitored for temperatures. A small refrigerator, in the dining area, was observed to have food items that the DFS indicated was not from the kitchen and looked to be food brought in from home for the residents. The freezer compartment had built-up ice/frost. A food item was observed to be on the top of the built-up ice/frost. The refrigerator had a temperature log that had one entry on [DATE] for a fridge temp of 30 and freezer temp of 10. On [DATE] at 11:48 AM, an interview was conducted with the Nursing Home Administrator (NHA) regarding the refrigerator in the dining area. An observation was made with the NHA of the freezer section. When queried regarding the cleaning of the freezer, the NHA indicated that maintenance pulls it and cleans it and stated, It looks like its been awhile. The Daily Refrigerator Temperatures log was reviewed with the NHA that had one entry for (NAME)that was completed on [DATE]. The logs were requested for the last three months. On [DATE] at 11:54, an interview was conducted with the Nurse Supervisor A regarding the temperature monitoring of the Resident refrigerator. When queried regarding a policy for the monitoring of the refrigerator, the Supervisor was not sure what the policy was. A review of the document Daily Refrigerator Temperatures reviewed with the Supervisor revealed, Instructions: Refrigerator/Freezer: Read and record the temperature daily, preferably after the door has been closed at least hour. The Supervisor indicated the temps were to be monitored daily. A review, of the facility document Daily Refrigerator Temperatures, for February 2020, revealed, 14 days for the month to have temperatures recorded and 15 days without monitoring of temps. A review of temperatures for the month of [DATE], revealed, 13 days for the month with recorded temps and 18 days with no recorded temperatures. A review, of the facility policy entitled, Food and Supply Storage, revised on ,[DATE], revealed, All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption . Procedures: Most, but not all, products contain an expiration date . Foods past the use by, sell-by, best-by or enjoy by date should be discarded. Cover, label and date unused portions and open packages. Complete all sections on a Morrison orange label, or use an approved labeling system . Date and rotate items . Discard food past the use-by or expiration date . A review, of the facility policy entitled, Food Handling Guidelines (HACCP), revised ,[DATE], revealed, .Contamination Precautions, Food shall be protected against cross-contamination by: appropriately separating types of raw animal products such as beef, fish, lamb, pork and poultry during storage and processing with the use of separate equipment or areas or by scheduling and cleaning .
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on interview and record review, the facility failed to identify and implement a yearly Quality Assessment Process Improvement (QAPI) Plan specific to the facility's population and concerns to enable correction of deficiencies necessary to ensure resident safety and quality of life, resulting in the likelihood for serious negative physical and psychosocial outcomes for all eleven residents at the facility. Findings Include: On 3/10/20 at 4:14 PM, during an interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235577	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCLAREN LAPEER REGION	1375 N MAIN ST LAPEER, MI 48446

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 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) Administrator, he provided a copy of an October 2018 QAPI Plan titled, Performance Improvement Plan. The Administrator was asked if there was a current facility QAPI Plan for 2019-2020, he said he did not have a current QAPI Plan for the Long-Term Care Facility. He provided a copy of the attached Hospitals QA plan for 2020. The plan was not specific to the Long Term Care Facility (TCU) and didn't mention the facility or their identified needs and focus areas. During the Entrance Conference, QA policies were requested with none received. When asked about this, the Administrator said they had identified areas of focus that needed to be addressed, such as Policies and Plans specific to the facilities resident population, needs and concerns.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on interview and record review, the facility failed to ensure the required composition of the Quality Assurance Process Improvement (QAPI) committee members were in attendance for 2 of 4 quarterly meetings, resulting in the potential to effect all 11 residents in the facility. Findings Include: On 3/11/20 at 4:41 PM, during an interview with the Administrator, the facilities QA PI process and meeting schedule was reviewed. The Administrator said the committee only met quarterly. A review of the Meeting Sign in sheets for (NAME)2019 to (NAME)2020 - indicated the Director of Nursing (DON) was not present for the (NAME)2019 and December 2019 meetings. Other nursing disciplines were present, but there was no documentation of the DON's attendance. The Administrator said there was a nurse acting on behalf of the DON for (NAME)and December 2019, but this was not indicated on the sign in sheets. A QA/QAPI policy was requested and the Administrator said the facility did not have one.
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 ensure that Infection Control standards of practice were followed for 1) Storage of resident care items to prevent contamination and 2) In the collection, analysis and reporting of infection surveillance data, resulting in potential exposure to infectious illness for all twenty-six residents in the facility. Findings Include: Infection Surveillance: On 3/10/20 at 1:30 PM, the facilities Infection Control Program was reviewed with Infection Control (IC) Nurse J, who said she began in the role in October 2019. The monthly surveillance logs from (NAME)2019-February 2020 were reviewed. The Infection Control (IC) Nurse J, said the facility used McGeer's Long Term Care Criteria for surveillance and identification of infections to determine Healthcare Associated Infections (HAI). The IC nurse said when a resident was placed on antibiotics, they were added to the surveillance log. When asked if resident's with infectious signs and symptoms who were not receiving antibiotics were identified and added to the log, she said No. They were not logged and compiled for monthly data. The IC nurse was asked how often the data was reported and said the facility met monthly, but the Medical Director attended the quarterly meeting that was held in the hospital with data presented by the hospital IC Nurse. The IC Nurse J provided a check off/tally form and said she sent raw numbers to the hospital IC Nurse who then compiled the data for the hospital. The data form did not ask for HAI or CAI (Community Acquired Infection), but only ex. UTI (Urinary Tract Infections). There was no way to tell if the information provided was total infections or HAI or CAI. When the IC Nurse was asked about this, she could not explain it. She said she was just supposed to put checks in each category ex. UTI and send it over to the hospital IC Nurse. During the interview, when IC Nurse J was asked if she analyzed monthly, quarterly, yearly data for trends and discussed the trends for potential interventions, she said No. While reviewing the Infection Surveillance Worksheet (Log) for November 2019, with the nurse, she said there were increased UTI's for the month- A Rash of UTI's. When asked if they were HAI or CAI, she wasn't certain. During the review, there were 8 documented UTI's for November 2019; none had an organism of infection listed. Four were listed as HAI, 2 as a CAI and 2 were not classified as either. The nurse was asked how the infections were determined to meet criteria for either an HAI or CAI and was unable to provide an answer or documentation to identify the infections, she said We were just unsure. Nurse J was asked why there were no organisms from a culture and sensitivity to ensure the appropriate infection was identified, determine if criteria were met and to treat the resident's infection appropriately, she said the lab did not culture the resident's urine samples. The IC Nurse was asked if she reviewed the U/A's to determine if they met criteria to perform a culture and sensitivity (c/s) and she said No. Nurse J was queried about the lack of urinary c/s and asked if there was criteria to even send the urine sample's to the lab, and she was not able to provide an answer. The IC Nurse was unable to determine if there was an increase in Urinary Tract Infections or not. On further review of the facilities Infection Surveillance data for (NAME)2019- February 2020, Nurse J was asked if she collected surveillance data based on McGeer's Criteria for each potential infection, as the Infection Surveillance Worksheet, in use did not include a column to identify signs and symptoms based on McGeer's Criteria for Long Term Care, including the onset of symptoms and was focused on antibiotic use and start and stop dates for the antibiotics. When asked for specific surveillance worksheets for the resident infections listed on the Surveillance logs, the nurse was only able to provide information for 2 residents (January 2020) during the yearly surveillance timeframe, saying she did not have surveillance data for each resident. During the interview, Nurse J said she had provided education to the staff related to the perceived increase in Urinary Tract Infections but was unable to provide documentation of the education or what the content was. On 3/10/20 at 3:30 PM, Education Nurse T and the IC Nurse were interviewed about staff education related to UTI's and Nurse T said the staff were assigned education in January 2020, on the computer and it wasn't due to be completed until the end of (NAME)2020. This was months after the IC Nurse had identified a potential problem. A review of the facility policy titled, Surveillance Definitions for Health Care-Associated Infections, dated effective January 2020 provided, Purpose: To define infections as healthcare associated, in accordance with National Healthcare Safety Network (NHSN) and the Centers for Disease Control (CDC). Policy/Procedure: The Infection Control Department will conduct ongoing surveillance using the NHSN 2020 Manual definitions and reporting instructions. The data will be compared with NHSN data for surveillance trending . The policy included the NHSN/CDC worksheets for infections and did not mention McGeer's Criteria for Long Term Care. The policy was a hospital focused document. On [DATE] at 1:17 PM, an observation was made during the initial tour of the facility, of room [ROOM NUMBER]'s bathroom. Two men shared the room and bathroom. An observation was made of a urinal placed on the toilet behind the seat with bath cloths stored between the piping of the toilet and the toilet seat. On [DATE] at 1:21 PM, an interview was conducted with Certified Nursing Assistant E regarding the urinal and wipes on the toilet behind the toilet seat. When queried regarding the storage of urinals, the CNA indicated they put the urinal on the rail near the toilet and the wipes are stored in a drawer in a wash basin. The CNA removed the items from behind the toilet seat and disposed of them. A review of the facility policy titled, Infection Control in TCU, revealed, .VIII. Reuse of resident care items .B. Bedpans and urinals will be cleaned with soap and water after each use .