STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235438	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMNWOOD OF MCBAIN	220 HUGHSTON ST MC BAIN, MI 49657

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 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** Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADLs) pertaining to incontinence care and toileting were provided for three Residents (#103, #104, and #107) of four residents reviewed for ADL assistance. This deficient practice resulted in residents being left incontinent or not toileted for long periods of time, increasing the risk of skin breakdown and causing impaired dignity. Findings include: Review of Resident #103's face sheet revealed an admission date of [DATE] and medical [DIAGNOSES REDACTED]. Resident #103'sMinimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating Resident #103 was cognitively intact. On 09/01/20 at 2:43 p.m., an observation was made of Resident #103's call light being on. The call light was responded to within one minute by Certified Nurse Aid (CNA) D. Resident #103 told CNA D they needed to use the bathroom. CNA D told Resident #103 the large bathroom was in use and Resident #103 would have to wait until it was available. During an interview on 09/01/20 at 3:12 p.m., Resident #103 stated they had been waiting to use the bathroom for a long time but now it was too late and they had wet their pants. A large amount of liquid having the odor of urine was observed under Resident #103's chair. Resident #103 reported this was the fifth time this has happened. Resident #103 said it made them feel bad when they don't get to the bathroom in time. A review of Resident #103's Electronic Medical Record (EMR) revealed a care plan dated 7/23/20 which included the following information, (Resident #103) is at risk for skin breakdown due to limited mobility due to a stroke, incontinence, and diabetes . Provide incontinence care with each incontinent episode . (Resident #103) is incontinent of bladder . Check q (every) 2 hr (hours)and prn (as needed) for incontinence. Wash, rinse and dry perineum. Change clothing after incontinence care as needed . A review of Resident #104's face sheet revealed an admission date of [DATE] and medical [DIAGNOSES REDACTED]. Resident #104's 5/7/20 MDS assessment revealed a BIMS score of 15/15 indicating Resident #104 was cognitively intact. During an interview with on 09/01/20 at 2:53 p.m., Resident #104 said have been are several days when they have asked to be changed at 3:30 a.m., but they will not get changed until after the day shift comes in at 7:00 a.m. Resident #104 said sitting in a wet brief for periods of time this long makes them feel like crap, especially when they have to eat sitting in a wet brief. During an interview on 9/1/20 at 3:33 p.m., CNA C reported there have been several shifts when they come on at 7:00 a.m. and several residents have saturated briefs. CNA C said Resident #104 has often been found soaking wet. Resident #104 has told CNA A they have been left in urine all night. During an interview on 9/2/20 at 7:03 a.m., CNA B reported on the morning of 8/29/20, Resident #104 had requested to be changed at 3:30 a.m. but CNA B had been unable to get them changed until day shift came in. Resident #104 was changed around 7:30 a.m. CNA B verified this meant Resident #104 had been incontinent for approximately four hours. During a follow up interview on 9/2/20 at 8:00 a.m., Resident #104 recalled on Saturday night/Sunday morning (8/28/20-8/29/20) they had asked to be changed early in the morning at approximately 3:30 a.m. but CNA B was unable to do it. CNA B had told Resident #104 there was not enough staff to assist with the incontinence care at that time. Resident #104 said it made them feel like crap that they had to wait that long in a wet bed. Resident #104 believed it was over three hours before they were changed. A review of Resident #104's EMR revealed a care plan dated 7/23/20 containing the following information, (Resident #103) has impaired skin integrity and is at risk for further impairment R/T (related to) [MEDICAL CONDITION], decreased mobility, moisture, hoyer lift use. Bilateral buttocks reddened, including gluteal folds . (Resident #104) reddened buttocks and gluteal folds will heal without complication .Provide incontinence care with each incontinent episode and as needed and apply moisture barrier cream/ointment . A review of Resident #107's face sheet revealed an admission date of [DATE] and medical [DIAGNOSES REDACTED]. Resident #107's 7/21/20 MDS assessment revealed a BIMS score of 9/15 indicating Resident #107 was mildly cognitively impaired. During an interview on 9/1/20 at 3:33 p.m., CNA A said Resident #107 has often had saturated briefs when CNA A does the first incontinence check at the beginning of the day shift which would be shortly after 7:00 a.m. CNA A reported Resident #107's bottom looks bad right now. On 09/01/20 at 4:36 p.m., an observation was made of Resident #104's incontinence care, as performed by CNA A and CNA D Resident #104's bottom was excoriated with an open area resembling a popped blister approximately 0.75 centimeters in diameter. Resident #104 was observed itching this open area during incontinence care. During an interview 09/02/20 at 9:02 a.m., Resident #107 reported there have been several nights when they are not checked for incontinence or changed from approximately 9:00 p.m. until the following morning after the day shift comes in. Sometimes it is as late as 9:00 a.m. before incontinence care is performed. When asked how this made Resident #107 feel, Resident #107 stated, There's not much I can do about it. During an interview on 9/3/20 at 11:00 a.m., Registered Nurse (RN) H reported Resident #107's bottom was reddened. RN H believed Resident #107 had a yeast infection. RN H reported being left incontinent for extended periods of time would be a significant contributing factor to the cause of the yeast infection. A review of Resident #107's EMR revealed a care plan which contained the following information, (Resident #107) is incontinent of bladder and requires assistance with toileting needs .Will remain free of complications(skin breakdown, UTI, etc) from incontinence . BRIEF USAGE: Resident uses large disposable briefs. Change q 2 hrs and prn . Check q 2 hr and prn for incontinence . On 9/3/20 at 11:57 a.m., concerns regarding delays in incontinence care and toileting were shared with Staff Educator/Unit Manager/ RN F. RN F reported the expectation was for CNAs to be checking and changing residents every two hours. Residents with a BIMS higher than 13 should be toileted or changed upon their request. RN F said these residents should be toileted or changed within 10 minutes of their request. Findings regarding Resident #103's approximate 30 minute wait on 09/01/20 were shared with RN F. RN F said Resident #103 should not have had to wait that long. RN F could see how it would have an impact on Resident #103's dignity. RN F was notified of Resident #104's and Resident #107's delay in being changed. RN F reported the CNAs would need further education. RN F was not sure why this had happened. The facility did not have a policy pertaining to the frequency of performing incontinence care and toileting.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safety of residents while performing transfers with a mechanical lift for three Residents (#101, #108, and #109) of three residents reviewed for mechanical lift transfers. This deficient practice resulted in the potential for injury to any residents being transferred with mechanical lifts. Findings include: On 09/02/20 at 7:39 a.m., Certified Nurse Aide (CNA) B reported they had transferred Residents #101, #108, and #109 with the sit to stand lift (a mechanical lift which used to transfer resdents from a sitting to standing position) on

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the 8/28/20 midnight shift without another staff member present to provide assistance. CNA B said there should always be two staff members present but there was not another staff member available to assist with the transfers. A review of Resident #101's Electronic Medical Record (EMR) revealed Resident #101 had been admitted on [DATE]. Resident #101 had medical [DIAGNOSES REDACTED]. Resident #101's care plan dated 8/27/20 contained the following information, (Resident #101) has an ADLs (activities of daily living) Self Care Performance Deficit and requires assistance with ADLs and mobility r/t (related to) obesity, weakness, and pain .TRANSFER: Sit to stand lift with two staff. A review of Resident #108's EMR revealed Resident #108 had been admitted on [DATE]. Resident #108 had medical [DIAGNOSES REDACTED]. Resident #108's care plan dated 7/23/20 contained the following information, (Resident #108) decline in function OR to maintain/slow decline secondary to non-pressure chronic ulcer L(left) .w/(with)necrosis (death)of muscle,[MEDICAL CONDITION], .muscle weakness, and difficulty in walking: Decline in gait/ambulation, .Decline in LLE (left lower extremity) ROM (range of motion), Decline in Transfer skills, Decreased LLE strength, Decreased mobility, Decreased RLE (right lower extremity) strength, Decreased sitting balance,Decreased standing balance, pain, . A review of Resident #109's EMR revealed admission on 8/9/19 with medical [DIAGNOSES REDACTED]. Resident #109's care plan dated 7/23/20 contained the following information, (Resident #109) assistance with ADL's and mobility r/t [MEDICAL CONDITION] and will refuse to let staff assist with transfers and will become agitated at times. Has [MEDICAL CONDITION] . TRANSFER: Sit to stand. During an interview with Staff Educator/Unit Manager/Registered Nurse (RN) F on 09/02/20 at 8:15 a.m., RN F reported the CNAs are trained to always have two staff members present when performing transfers with any type of mechanical lift. RN F said it was not safe to do the transfers with only one staff member because it increased the risk of resident falls. The standard practice was to always have two staff members present. On 09/02/20 at 2:41 p.m., the Nursing Home Administrator (NHA) confirmed transfers using the lifts were always to be performed with two staff members. The NHA was aware there had been a staff member who had thought sit to stand transfers could be performed with one staff member and they had been educated on this. The facility's Transfer with a Hydraulic Lift policy with the most recent revision date of 5/15/20 contained the following information, Critical Notes All mechanical lifts require two staff members to be present.