STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235491	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - ROSEVILLE	25375 KELLY RD ROSEVILLE, MI 48066

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 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, families, and visitors of the location of the survey results for seven confidential residents who attended a confidential group meeting, resulting in the potential for residents, families, and visitors to be uninformed of the facility's deficient practices. Findings include: During a Confidential Group meeting that was conducted in the facility on 3/10/20 at 4:12 PM, all seven residents who attended the meeting verbalized that they were unaware of the location of the most recent and past survey results. Confidential Group R1 stated, I know where the survey results are supposed to be kept, I've asked a few times but have never seen them. On 3/11/20 at 7:35 AM, an attempt was made to locate the Survey Binder which contained the facility's survey results. The Survey Binder was unable to be located. On 3/11/20 at 7:41 AM, Admissions Coordinator (AC) L whose office was located in the front lobby, was queried on the location of the facility's Survey Binder. AC L stated, I'm not sure, it might be by the nurses station. On 3/11/20 at 7:44 AM, Unidentified Certified Nurse Assistant (CNA) M who was standing at the First Floor North Nurses Station was queried on if the knew where the State Survey Binder was located. Unidentified CNA M stated, No. On 3/11/20 at 7:48 AM, a binder titled Survey Book Advantage Living Center Roseville was observed to be lying on a counter across from the Administrator's office. No observed information was posted in any part of the facility notifying residents, families, and/or visitors of the location of the Survey Binder. On 3/11/20 at 8:30 AM, the Facility Administrator was queried regarding the location and access to survey results for residents, families, and/or visitors. The Administrator stated, The Survey Book should be located in the front lobby. The Administrator indicated that it had been located in a clear plastic hanging box attached to the wall in the lobby. The Administrator further indicated that the lobby had been recently painted and that the hanging box had been removed from the wall. On 3/11/20 a policy was requested from the facility regarding informing residents, families, and visitors of the location of survey results. The Administrator stated, There is no policy, but it should be located in the front lobby.
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 that sufficient nursing staff were available to meet resident incontinence care and nail care needs for three sampled residents (R73, R90 and R103) resulting in, unmet resident care needs and dissatisfaction with care. Findings include: R73 On 3/10/20 at 10:48 AM, during an initial tour of the facility, R73 was queried about their care at the facility and stated, I wait two or three hours for a brief change, I wet myself frequently. R73 was asked how waiting to have their brief change made them feel, and stated, I feel like an animal. On 3/12/20 at 3:30 PM, R73 was further queried about their care at the facility and stated, I have to sit in my own pee for hours R73 indicated that this frequently occurs on the afternoon shift. R73 was asked how it made them feel and stated, Degraded. On 3/12/20 a review of R73's Care Plan indicated the following, Focus, I am incontinent of Bowel/or bladder. Date Initiated: 08/24/2018. Revision On: 11/27/2018. Interventions: Check me at least every two hours during the day and change my brief if needed. Date Initiated: 08/24/2018. On 3/12/20 a review of R73's medical record was conducted and revealed the following, R73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R73's most recent Minimum Data Set Assessment ((MDS) dated [DATE], indicated that R73 was Occasionally incontinent of Bowel/Bladder, and revealed an intact cognition, and extensive assistance needed of one person for toileting. R103 On 3/12/20 at 11:20 AM, R103 was met in their room for observation and interview. R103 stated, I've been waiting since 9:00 AM, for someone to change me, I stink. R103 indicated that they had defecated in their brief. R103 was queried on if they had activated their call light. R103 smiled and stated, Three Certified Nursing Assistants (CNAs) came in here and told me that they didn't have time to help me. On 3/12/20 R103's Care Plan was reviewed and revealed the following, Focus, I am incontinent of Bowel .Date Initiated: 11/08/2017. Goal, I will be free of odor while maintaining my dignity. Date Initiated: 11/08/2017. Revision Date: 07/10/2019. Target Date: 05/24/2020. Interventions, Check me at least every two hours during the day and change my brief if needed. Date Initiated: 11/08/2017. On 3/12/20 a review of R103's medical record was conducted and revealed the following, R103 was admitted to the facility with a [DIAGNOSES REDACTED]. On 3/12/20 at 3:45 PM, the Director of Nursing (DON) was queried on their expectations for staff responding to residents care needs. The DON stated, I expect staff to answer call lights in a timely manner. They should acknowledge the light and acknowledge the resident. The DON indicated that staff should give the resident a time frame of when they are going to assist them. On 3/12/20 at 3:58 PM, the Administrator was queried on their expectations for staff responding to residents care needs. The Administrator indicated that staff should be following the facility policy for answering call lights. Resident #90 On 3/10/20 at 12:02 PM, during the initial tour, R90 was observed in bed with their nightgown on. 90 was observed with two scratches on their left temporal area. R90 was asked how they obtained the scratches on their face. R90 said, I scratched myself. I scratch my whole body because I itch. R90's fingernails on both hands were observed to be long extending past the top of the resident's fingers, with a build-up of dark unknown substance underneath them. R90 was asked about having their nails trimmed by staff. R90 said, I should probably ask them to cut my nails so that I won't keep scratching myself. On 3/11/20 at 11:48 PM, R90 was observed in bed. Their nails remained with a build-up of dark unknown substance underneath them. On 3/11/20, A review of the electronic medical record noted R90 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R90 was cognitively intact R90 required extensive assistance with activities of daily living. The care plan initiated 5/5/16 noted, Personal Hygiene: I need extensive assistance x1 from you with personal hygiene and oral care .Anticipate and meet my needs. On 3/12/20 at 10:23 AM, Nurse Manager K was interviewed and queried about the scratches on R90's temporal and the length of the residents fingernails. Nurse Manager K said, She does not like her nails done. A review of the progress notes did not note refusal of nail care. On 3/12/20 at 11:15 AM, the Director of Nursing (DON) was interviewed and queried about the scratches and his expectation of the staff providing nail care. The DON said, The staff are supposed to give nail care during the resident's showers. On 3/12/20, facility policies titled, Staff Schedule Review with no date and Daily Unit Rounds with no date, were reviewed. Neither policy addressed Activities of Daily Living Care (ADSL) of residents.
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**

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

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview and record review, the facility failed to operationalization policies and procedures for Resident focused assessment and timely implementation of relevant interventions for pressure ulcer (wounds caused by pressure) prevention for three (#'s 58, 48, and 87) of five Residents reviewed for pressure ulcers, resulting in Resident #58 developing two unstageable (full thickness tissue loss with base of the ulcer obscured) pressure ulcers, Resident #48 developing two stage three (full tissue loss) pressure ulcers, Resident #84 developing a stage two (partial thickness tissue loss) pressure ulcer, unnecessary pain, potential infection, and the likelihood for decline in overall health status. Findings include: Resident #58 On 3/10/20 at 11:47 AM, Resident #58 was not in their room. Observation of the Resident's room revealed the Resident's bed was positioned directly against the wall in the room. An alternating air mattress (specialty mattress for pressure reduction) was in place on the Resident's bed. Review of facility provided documentation entitled, Facility Acquired Pressure Ulcers revealed Resident #58 had developed a pressure ulcer while a Resident at the facility. At 2:55 PM on 3/10/20, Resident #58 was observed sitting in a wheelchair in the main dining/activity room. An interview was conducted with the Resident at this time. When asked if they were having pain, Resident #58 replied, Yes, my legs. I got a sore there. Resident #58 was noted to be sitting with their legs together and knees touching in the wheelchair. When asked what the sore was from and the severity of their pain on a scale from zero to 10, Resident #58 was unable to provide an explanation. Resident #58 was then asked where the pain was located in their legs and replied, Where the sores is. Record review revealed Resident #58 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required extensive assistance to perform all Activities of Daily Living (ADLs) with the exception of eating. The MDS further revealed the Resident was at risk for pressure ulcer development but did not have any pressure ulcers. Additional review of the medical record revealed the resident had a history of [REDACTED]. An interview was conducted with the facility Wound Care Nurse, Licensed Practical Nurse (LPN) B on 3/11/20 at 9:07 AM. When queried regarding Resident #58 current pressure ulcers, Wound Care Nurse LPN B revealed the Resident had, Medial inner knee pressure ulcers status [REDACTED]. On 3/11/20 at 2:03 PM, an observation occurred of Resident #58 in their room. Upon knocking and entering the room, Resident #58 was observed in their bed, positioned on their right side with their knees bent. The right knee was bent at approximately a 95-degree angle and their left knee was at approximately 100-degree angle. The Resident was displaying non-verbal signs/symptoms of pain. When asked if they were in pain, Resident #58 replied, Yeah. Nursing Assistant E was present in the room. An open wound not covered by a dressing was noted on the Resident's right medial (inside) knee. The open wound was slightly larger than a half dollar in width and irregularly shaped. The wound bed had dark brown/black colored tissue in the center and was surrounded by red tissue with visible tissue loss and unattached edges. A dressing was in place on the Resident's left medial knee. The dressing was visibly saturated with red colored drainage. A [MEDICATION NAME] (non-latex adhesive) dressing, not contained in a package, with the removable backing intact was noted laying directly on the Resident's over-bed table. The dressing had 3/11 written on it. Nursing Assistant E picked up the dressing and continued to hold it in their hand. At this time, Wound Care LPN B was noted in the shared bathroom between Resident #58 room and the adjoining Resident room. LPN B exited the bathroom and took the dressing from Nursing Assistant E's hand. When asked what the dressing was for, LPN B did not initially provide a response and then stated, Well it was for (Resident #58). LPN B then revealed the pressure ulcer looked different. When asked about the stage of the pressure ulcer, LPN B stated, It's unstageable now. LPN B then proceeded to exit the room without applying a dressing over the open wound. Nursing Assistant E then covered the Resident with the blankets that were present on their bed. When asked about the Resident's pressure ulcer, Nursing Assistant E revealed the dressing came off every time they took off the Resident's pants. When queried if the wound looked different and how, Nursing Assistant E replied, No. Resident #58 was then queried if they were able to bend their knees and the Resident indicated they were not really able to move their legs. When queried if their legs rubbed or if their knees touched when they sat in their wheelchair, Resident #58 replied, Yeah. With further discussion, Resident #58 revealed their mother told them to sit with their legs together. At this time, Nursing Assistant E was queried if the Resident's legs were contracted and revealed they were. Nursing Assistant E further revealed they had been trying to put a pillow in-between the Resident's knees when they were in bed during the day. Review of Resident #58's medical record revealed the following care plan, I have impaired skin integrity on my Right Medial Knee Unstageable pressure, (cicatrix- healed pressure ulcer tissue) Left Medial Knee, s/p (status [REDACTED]. (Initiated: 3/11/20; Revised: 3/12/20). Care plan interventions included: -Administer my treatments as ordered and monitor for effectiveness (Initiated: 10/18/19) -Assess/record/monitor my wound healing. Measure length, width and depth where possible. Assess and document the status of my wound healing progress. Report my improvements and declines to my Dr. (Initiated: 10/18/19) -Assist in repositioning me frequently in my bed or chair (Initiated: 10/18/19) -Ensure my wheelchair arms are padded (Initiated: 10/18/19) -I need a pressure reducing mattress on my bed (Initiated: 10/18/19) -I need a full body sling for transfers (Initiated: 10/18/19) An interview was completed with Physician D and Wound Care Nurse LPN B on 3/11/20 at 3:00 PM. When queried regarding Resident #58, Physician D stated, (Resident #58's) wounds don't look good. They (wounds) are from pressure. When queried regarding interventions, Physician D replied, Have to keep the pressure off (the area). When queried regarding observation of the Resident sitting with their legs together in their wheelchair and no interventions in place in the care plan pertaining to the pressure reduction for the Resident's knees and legs, LPN B revealed they were not aware of the Resident sitting with their legs together and would implement interventions. When asked why interventions were not in place previously, with the Resident's history of pressure ulcers, LPN B indicated the Resident had other interventions in place including an air mattress. An interview was completed with Wound Care Nurse LPN B on 3/12/20 at 10:29 AM. When queried how often wound care assessments are completed and documented for Resident's with pressure ulcers, Wound Care Nurse LPN B replied, Once a week. When asked where wound care assessments are documented, Wound Care Nurse LPN B revealed assessments are documented in the Weekly Wound Healing Record- Wound Care Nurse under the assessment tab in the Electronic Medical Record (EMR). On 3/12/20 at 10:38 AM, wound care treatment observation was completed with Wound Care Nurse LPN B and Nursing Assistant E. Upon entering the room, Resident #58 was observed in bed, positioned on their right side with no pressure reduction interventions in place between the Resident's legs. LPN B removed the dressing from the Resident's right medial knee pressure ulcer. The wound was irregularly shaped. The wound bed had dark brown/black colored tissue in the center with off-white and red colored tissue surrounding the dark tissue. LPN B measured the length and width of the wound and stated, It's 3.5 (centimeters -cm) by 2 (cm). LPN B proceeded to cleanse the wound and apply a new dressing. LPN B then removed the dressing covering the pressure ulcer on the Resident's left medial knee. A healed wound proximal to the open wound was observed on the Resident's left knee. When queried regarding the healed wound, LPN B revealed the area was cicatrix (scar tissue) from a healed pressure ulcer. The open wound was irregularly shaped, and a small amount of light red drainage was noted on the removed dressing. The wound bed had a dark brown/black area in the center and was surrounded by red and then off-white colored tissue. LPN B measured the wound and stated, It's 3.5 (cm) by 1.5 (cm). Nurse B then cleansed and applied a new dressing to the wound. An interview was conducted with Unit Manager LPN G on 3/12/20 at 12:10 PM. When queried what interventions were in place to prevent pressure ulcer development for Resident #58 prior to the current pressure ulcers developing on their left and right medial knees, Unit Manager LPN G reviewed the Residents medical record and stated, A pillow between knees around the clock was ordered on [DATE]. When asked why no interventions were implemented prior to the Resident developing two unstageable pressure ulcers when they had a history of [REDACTED]. Review of Resident #58's medical record revealed the following progress note documentation: -3/6/20 at 12:28 PM: Nurses Note . Writer called to therapy gym r/t (related to) open areas observed on bilateral inner knees. Wound consult ordered. Treatment in place for cushioned gauze pending wound care consultation. -3/11/20 at 3:32 PM: Skin/Wound Note . Writer observed Right Medial knee unstageable necrotic wound base with yellow slough surrounding tissue with scant drainage, flat edge. Left Medial, Upper Leg S/P (status [REDACTED]. (Physician D) present at bed side .Therapy, Dietitian, and guardian notified. Review of Resident #58's Weekly Wound Healing Record- Wound Care Nurse Assessment documentation revealed last wound care assessment completed for Resident #58 was dated 11/26/19. An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 3:35 PM. When queried regarding Resident #58 developing two unstageable pressure ulcers in the facility, having a history of pressure ulcers as well as contractures, and interventions implemented by the facility to prevent pressure ulcer development, the DON indicated the Resident has a care plan for fall prevention which included an intervention of the provision of pillows to encourage good body alignment. When queried if that care plan and intervention was implemented in regards to pressure prevention, the DON indicated they were not able to answer the question. When asked if interventions should have been implemented to prevent pressure ulcer development due to the Resident's history, contractures, and risk for pressure ulcer development, the DON indicated other interventions were in place including an

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) alternating air mattress. No further explanation was provided. When queried why a Weekly Wound Healing Record- Wound Care Nurse assessment had not been completed, the DON was unable to provide an explanation. Resident #48 At 11:15 AM on 3/10/20, Resident #48 was observed in the central dining/activity room of the facility. The Resident was sitting in a geri-chair (large, reclining, wheeled chair). The geri-chair did not have a pressure reduction pad in place on the seat base. Wound dressings were noted on both of the Resident's feet. Review of facility provided documentation entitled, Facility Acquired Pressure Ulcers revealed Resident #48 had developed a pressure ulcer while a Resident at the facility. Record review revealed Resident #48 was most recently readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident was at risk for pressure ulcer development but did not currently have a pressure ulcer. Additional record review revealed Resident #48 was admitted to Hospice services on 10/9/19. On 3/11/20 at 8:49 AM, Resident #48 was observed in their room, sitting in a geri-chair. The geri-chair did not have a pressure reduction pad in place on the seat base. Dressings were noted on both of the Resident's feet. When spoke to, the Resident would make eye contact and smile but did not provide meaningful responses when asked questions. An interview was conducted with Wound Care Nurse LPN B on 3/11/20 at 8:51 AM. When queried regarding Resident #48, Wound Care Nurse LPN B stated, (Resident #48) came back to the facility from the hospital and their heels were red. (Resident #48) developed some (pressure) ulcers there. When asked if there were pressure ulcers on both of the Resident's heels, LPN B replied, Yeah, stage three. Review of Resident #48's care plans revealed the following, I have impaired skin integrity, h/o (history of) altered skin integrity on my Sacrococcyx/bilateral buttocks . (Initiated: 8/17/19; Revised: 11/5/19). The care plan included the interventions: -Administer my treatments as ordered and monitor for effectiveness (Initiated: 8/17/19) -I need a full body sling for transfers (Initiated: 8/17/19) -I need assistance to turn/reposition at least every 2 hours, more often as needed or requested (Initiated: 8/17/19) -I require a pressure reducing device in my chair - including a geri-chair (Initiated: 8/17/19) -Observe my dressing to ensure it is intact and adhering. Report my loose dressing to my nurse (Initiated: 8/17/19) -There will be weekly documentation as to the progress of my healing (Initiated: 8/17/19) -I need a pressure reducing mattress on my bed (Initiated: 8/17/19) The care plan did not include interventions specific to pressure reduction/prevention for the Resident's heels. Review of Resident #48's medical record revealed the following progress note documentation: -12/12/19: Nurses Note . Black area noted to L (left) heel. Uni-boots ordered. Wound care notified. Hospice nurse notified. Review of Weekly Wound Healing Record-Wound Care Nurse Assessment documentation dated 11/7/19 revealed the pressure ulcer on Resident #48's right heel was acquired on 11/5/19. The assessment detailed, Type: Eschar (tissue seen in stage four or unstageable pressure ulcers) . Measurements . Length: 4.5 (cm) . Width: 5 (cm) . Review of the most recent Weekly Wound Healing Record-Wound Care Nurse Assessment for Resident #48's right heel, dated 2/27/20, detailed the following, Type: Pressure . Overall Impression: Unchanged . Necrotic tissue present . Measurements . Length: 1.4 (cm) . Width: 2.5 (cm) . Depth: 0.2 (cm) . Irregular edges . Treatment . [MEDICATION NAME] gel (wound treatment) daily and PRN (as needed) - Right heel, Left heel . Wound Progress: Right heel is a Stage 3 . not healed . Review of Weekly Wound Healing Record-Wound Care Nurse Assessment, dated 2/27/20, for Resident #48's left heel pressure ulcer revealed the pressure ulcer was acquired on 12/12/19. The assessment detailed, Type: Pressure . Pressure Ulcer Stage: 3 . Overall Impression: Unchanged . Measurements . Length: 0.5 (cm) . Width: 1 (cm) . Depth: 0.2 (cm) . Wound Progress: Left heel is a Stage 3 . not healed . At 2:42 PM and 4:01 PM on 3/11/20, Resident #48 was observed in their room. The Resident was in bed, positioned on their back. On 3/12/20 at 8:47 AM and 9:15 AM, Resident #48 was observed in their room in bed. The Resident was positioned on their back. Wound care observation for Resident #48 occurred on 3/12/20 at 9:21 AM with Wound Care Nurse LPN B and Nursing Assistant F. LPN B removed the dressing from the Resident's right heel. A small amount of red colored, thin consistency drainage was noted on the removed dressing. The wound was directly over the Resident's heel, slightly larger than a quarter in size and had irregular edges. The wound bed was black in color with unattached edges on the lateral side of the wound. The black area of the wound bed was surrounded by red/purple colored tissue. LPN B measured the black area of the wound bed and stated, It's 2 (cm) by 2.8 (cm). LPN B then cleansed the wound, applied [MEDICATION NAME] (medicated ointment), and covered the pressure ulcer with a dressing. LPN B proceeded to complete the dressing change on the Resident's left heel and removed the dressing covering the wound. The removed dressing had a small amount of gray/green colored drainage which was noted to have a slightly foul odor. The wound was irregularly shaped and slightly larger than a pencil eraser. The wound bed was black in color and surrounded by dark red colored tissue. LPN B measured the wound at this time and stated, It's 1 (cm) by 1 (cm). LPN B then cleansed the wound and applied a new treatment and dressing. Following completion of wound care, Resident #48 was positioned on their back in bed by LPN B and Nursing Assistant F. On 3/12/20 at 10:08 AM, Resident #48's geri-chair was observed in the hall outside of their room. The geri-chair did not have a pressure reduction cushion in place on the seating area of the chair. An interview was conducted with Wound Care Nurse LPN B at this time. When asked if the geri-chair in the hall belonged to Resident #48, LPN B indicated the geri-chair did belong to Resident #48. When queried if Resident #48 was supposed to have a pressure reduction cushion in their geri-chair, LPN B replied, Supposed to. When asked why there was not a pressure reduction cushion in the Resident's geri-chair, LPN B looked in the Resident's room for a cushion. After not locating a pressure reduction cushion, LPN B stated, I will get one. No further explanation was provided. R87 On 03/10/20 at 11:05 AM, R87 was observed lying in bed on their back with the head of the bed elevated about 30 degrees and on a low air loss mattress (to prevent or treat pressure ulcers) and heel protectors on both legs. R87 was interviewed regarding pressure ulcers and stated, I had the ones on my feet but now my butt has a sore. R87 was asked if the staff help with turning an repositioning and stated, I can turn. At 1:48 PM, and 4:16 PM, R87 was observed in the same position, and no positioning wedge was observed on the bed. On 03/11/20 at 6:31 AM, R87 was observed sleeping on their back with the head of the bed elevated 30 degrees. At 12:58 PM, R87 was observed attempting to reposition self in bed with great difficulty and settles back onto their back. At 2:45 PM, R87 was observed sleeping in bed on their back with the head of the bed elevated 30 degrees. No positioning wedge was observed on the bed. On 03/12/20 at 7:54 AM, R87 was observed sleeping in bed on their back with the head of the bed elevated 30 degrees. No positioning wedge was observed on the bed. On 03/12/20 at 8:30 AM, Certified Nurses Aide (CNA) C was asked if R87 needed assistance turning and repositioning and stated, (R87) needs help with the legs mostly and will ask for help. (R87) is cooperative and doesn't refuse. On 03/12/20 at 11:40 AM, a pressure ulcer care observation was scheduled with LPN B but R87 was difficult to awaken and needed medical attention. R87 was sent to the hospital. Record review revealed that R87 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Most recent Minimum Data Set (MDS) assessment dated [DATE], revealed R87 had a Brief Interview for Mental Status (BIMS) score of 13 indicating an intact cognition and needed extensive assistance with Activities of Daily Living (ADLs) including bed mobility. The MDS section B-1 dated 11/13/19 revealed R87 had no Stage 2 pressure ulcers upon admission. Review of the MDS section B-1 dated 02/13/20 revealed R87 had one Stage 2 pressure ulcer. R87's Medication Administration Record [REDACTED]. R87's care plan initiated on 01/31/20 and revised on 02/27/20, Focus. I have impaired skin integrity on my Left Buttock r/t (related to) Stage 2 Pressure Ulcer . Goal. I will show signs of healing and remain free from infection . Interventions. Assist in repositioning me frequently in my bed or chair. Encourage me to make small frequent position changes, I need assistance to turn/reposition at least every two hours, more often as needed or requested, and Use positioning wedge to off load left buttock. An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 3:35 PM. When queried regarding Resident #48's facility acquired pressure ulcers, the DON indicated the Resident was receiving Hospice services. When queried regarding the Resident's history of pressure ulcers and lack of implemented interventions, the DON did not provide an explanation. Review of the facility's undated policy and procedure titled, Facility-Acquired Pressure Ulcers revealed 5. When a pressure ulcer is identified, the licensed nurse will document in the progress notes and on the Weekly Wound/Skin Healing Record, to include size, stage, location, drainage, and odor; obtain treatment order, initiate a care plan, and notify the interdisciplinary team, including the dietitian. The policy and procedure did not specify interventions.
F 0688 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a restorative nursing program for four

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F 0688 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) (#'s 58, 48, 36, and 45) of eight Residents reviewed for limited Range of Motion (ROM) resulting in lack of treatment and services to maintain, increase and/or prevent reduction in ROM, increased limitations in ROM, Resident #58 developing contractures, and the likelihood for functional decline, diminished mobility, and pain. Findings include: Resident #58 On 3/10/20 at 2:55 PM, Resident #58 was observed in the main dining/activity room of the facility. The Resident was sitting in a wheelchair with their legs together and knees touching. An interview was conducted with the Resident at this time. When asked if they were having pain, Resident #58 replied, Yes, my legs. I got a sore there. When asked what the sore was from and the severity of their pain on a scale from zero to 10, Resident #58 was unable to elaborate. When asked if they were able to move their legs, Resident #58 revealed their legs were stiff and they were unable to walk. Record review revealed Resident #58 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required extensive assistance to perform all Activities of Daily Living (ADLs) with the exception of eating. The MDS further revealed the Resident had functional limitation in ROM on one side of their lower extremities and was not receiving Physical, Occupational, and/or restorative nursing therapy/services. On 3/11/20 at 2:03 PM, Resident #58 was observed in their room in bed. Nursing Assistant E was present in the room. Resident #58 was positioned on their right side with their knees bent. Their right knee was bent at approximately a 95-degree angle and their left knee was bent at approximately 100-degree angle. When asked if they were able to bend their knees, Resident #58 revealed they had limited ROM in their legs. An interview was completed with Nursing Assistant E at this time. When queried if the Resident's legs were contracted, Nursing Assistant E revealed they were. When asked if the Resident was receiving therapy or restorative nursing, Nursing Assistant E divulged they were not aware of the Resident receiving therapy. Review of Resident #58's care plans revealed the Resident did not have a current care plan in place related to completion of Range of Motion (ROM). An interview was conducted with Restorative Nursing Manager U and MDS Nurse H on 3/11/20 at 3:26 PM. Restorative Nursing Manager U was asked if Resident #58 was receiving restorative nursing services and replied, No. With further inquiry, Restorative Nursing Manager U stated, (Resident #58) was discharged from restorative at the end of January. When queried regarding the Resident's limitations in ROM, Restorative Nursing Manager U indicated the Resident was currently receiving therapy services. Documentation pertaining to the Resident's limitations in ROM and restorative nursing documentation was requested at this time. On 3/12/20 at 10:48 AM, the facility Administrator provided documentation of Resident ROM documentation. Review of requested documentation did not include any information/documentation for Resident #58. On 3/12/20 at 2:43 PM, an interview was conducted with Therapy Director V. When queried regarding Resident #58's ROM, Therapy Director V stated, (Resident #58) has severe limitations in ROM in their lower extremities. When asked if the Resident has always had limitations in lower extremity ROM, Therapy Director V replied, Well, I have worked here for five years and not always. Therapy Director V was asked when the limitations developed, and Therapy Director V revealed they were not sure when the limitations developed. Resident #58's therapy documentation was reviewed with Therapy Director V at this time. During review, Therapy Director V revealed Resident #58 was evaluated by therapy in October 2019. Therapy Director V stated, (Resident #58) was picked up (by therapy services) for increased pain in their right knee. When queried regarding the Resident's lower extremity ROM at that time, Therapy Director V stated, Lower extremity ROM was within functional limits. Therapy Director V revealed the Resident received Physical Therapy from 10/16/19 until 11/14/19 and were referred to restorative nursing upon discharge. Therapy Director V further revealed the Resident was currently receiving therapy services. When queried regarding the date Resident #58 was evaluated for current therapy care, Therapy Director V revealed the start of care for therapy for Resident #58 was 2/19/20. When asked about Resident #58's ROM when evaluated on 2/19/20, Therapy Director V reviewed the Resident's medical record and stated, Impaired ROM in the right and left lower extremities. When asked if the Resident's ROM decreased while receiving therapy, Therapy Director V indicated it had not. When asked how the Resident could develop those limitations in ROM if they were receiving restorative nursing services, Therapy Director V indicated they were unsure how those limitations would have developed if ROM was being completed. Review of Resident #58's Physical Therapy Evaluation and Plan of Treatment documentation revealed the following: -Start of Care Date: 10/16/19: Musculoskeletal System Assessment . LE (Lower Extremity) ROM . RLE (Right Lower Extremity) ROM = WFL (Within Functional Limits); LLE (Left Lower Extremity) = WFL . Functional Limitations Present d/t (due to) contracture = No . Clinical Impressions .recently refer to skilled therapy secondary pt (patient) demonstrated decline in functional status, pain in right knee increased . -Start of Care Date: 2/19/20: Musculoskeletal System Assessment . RLE ROM = Impaired; LLE = Impaired . RLE ROM . Knee = Impaired (80-degree extension) . LLE ROM . Knee = Impaired (95-degree extension) . Functional Limitations Present d/t (due to) contracture = Yes . Review of Resident #58's progress note documentation revealed the following: -12/20/19: Nurse Practitioner Notes . Right knee . Unable to fully extend knee; in flexed position. Stiff . Assessment/Plan: Stiffness of right knee vs. muscle contracture . The progress notes did not contain any documentation pertaining to restorative nursing. Resident #48 On 3/10/20 at 11:15 AM, Resident #48 was observed in the central dining/activity room of the facility. The Resident was sitting in a geri-chair with their eyes closed. The Resident's toes were pointed away from their body, with their ankle joint at approximately a 180-degree angle. Record review revealed Resident #48 was most recently readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident had functional limitation in ROM in one side of their upper extremities, both lower extremities and was not receiving Physical, Occupational, and/or restorative nursing therapy/services. Additional record review revealed Resident #48 was admitted to Hospice services on 10/9/19. On 3/11/20 at 8:53 AM, Resident #48 was observed in their room. The Resident was sitting in a geri-chair (large, reclining, wheeled chair) with their feet pointed away from their body and their ankles at approximately a 180-degree angle. The Resident's upper body was leaning to the left side in the geri-chair. An interview was attempted to be completed with the Resident at this time. When spoke to, the Resident would make eye contact and smile but did not provide meaningful responses to questions. Review of Resident #48's care plans revealed the Resident did not have a current care plan in place for restorative nursing services. Review further revealed the last Restorative care plan for Resident #48 was resolved (discontinued) in December 2018. An interview was conducted with Restorative Nursing Manager U and MDS Nurse H on 3/11/20 at 2:58 PM. When queried regarding Resident #48, Restorative Nursing Manager U revealed the Resident was not receiving restorative. When queried if Resident #48 had previously received restorative nursing, Restorative Nursing Manager U reviewed their documentation and revealed they did not have documentation prior to January 2019 due to when they assumed the restorative manager role. Restorative Nursing Manager U then stated, Not since January 2019 and indicated they did not have any records of the Resident receiving restorative nursing. Restorative Nursing Manager U further indicated the Resident was on Hospice and that Hospice Residents do not receive restorative nursing services. When queried if limitations in ROM and contractures are painful, Restorative Nursing Manager U and MDS Nurse H both replied, Yes. When asked why restorative services were not provided to prevent limitations in ROM and contractures for comfort and pain prevention, Restorative Nursing Manager U indicated Passive ROM (PROM) is completed by nursing assistant staff during daily care. When asked if ROM during daily care is the same purposeful ROM which is completed by restorative staff, Restorative Nursing Manager U and MDS Nurse H both replied, No and further revealed ROM performed during daily care does not provide the same benefit as ROM completed by restorative nursing staff. When queried if Resident #48's ROM had been evaluated by therapy staff, Restorative Nursing Manager U revealed therapy staff evaluate Residents quarterly. Documentation of Resident #48's ROM evaluations/assessments and any restorative documentation were requested from Restorative Nursing Manager U at this time. On 3/12/20 at 10:48 AM, the facility Administrator provided Resident ROM documentation. Review of requested documentation did not include any information/documentation for Resident #48. An interview was conducted with Therapy Director V on 3/12/20 at 2:43 PM. When queried regarding Resident #48's ROM, Therapy Director V reviewed the Resident's medical record and revealed Resident #48's last therapy certification period was from 10/1/19 to 10/30/19. When asked if the Resident had contractures at that time, Therapy Director V stated, Their Right Lower Extremity (RLE) was Within Functional Limits (WFL) and their Left Lower Extremity (LLE) was impaired but their hip was normal. When asked about the ROM in the Resident's ankles, Therapy Director V stated, Ankles were within functional limits at that time. Documentation pertaining to most recent therapy evaluations for Resident #48 were requested again at this time. Review of provided Resident #48's Physical Therapy Evaluation and Plan of Treatment documentation revealed the following: -Start of Care Date: 10/1/19: Musculoskeletal System Assessment . RLE ROM = WFL; LLE = Impaired . LLE ROM . Knee = Impaired; Ankle = WFL . Functional Limitations Present d/t (due to) contracture = No . Reason for Skilled Services . increase LE ROM and strength . Resident #36 On 3/11/20 at 10:05 AM, Resident #36 was observed in their room. The Resident was laying in bed, positioned on their back. The Resident was dressed

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	235491	A. BUILDING _____ B. WING _____	03/12/2020

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F 0688 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) in a hospital gown. Resident #36's right hand was clenched in a fist position and their left hand was covered with a blanket and not visible. The Resident did not respond verbally or non-verbally when asked questions. Record review revealed Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 1/10/20, revealed the Resident was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident had functional limitation in ROM on both sides of their upper and lower extremities and were not receiving Physical, Occupational, and/or restorative nursing therapy/services. On 3/11/20 at 1:39 PM and 2:40 PM, observation occurred of Resident #36 in their room. The Resident was in bed and wearing a hospital gown. Resident #36's right hand was clenched in a fist position and their left hand was covered with a blanket and not visible. Review of Resident #36's care plans revealed the Resident did not have a care plan in place related to completion of range of motion. An interview was conducted with Restorative Nursing Manager U and MDS Nurse H on 3/11/20 at 3:26 PM. When queried regarding Resident #36's ROM and if they were receiving restorative nursing services, Restorative Nursing Manager U and MDS Nurse H reviewed the Resident's medical record and indicated the Resident was not receiving restorative services. MDS Nurse H stated, No, (Resident #36) is Hospice. When asked about completion of ROM including PROM for comfort, MDS Nurse H stated, That would be with daily care. When asked how the Resident is getting lower extremity ROM when they have been wearing the same hospital gown, Restorative Nursing Manager U replied, With daily brief changes. When queried if ROM completed while changing a brief is the same as ROM completed by restorative nursing staff, Restorative Nursing Manager U and MDS Nurse H both replied, No. When asked if contractures are painful, Restorative Nursing Manager U and MDS Nurse H both replied, Yes. When asked if restorative nursing services are provided, per facility policy/procedure, to Residents receiving Hospice services to prevent limited ROM, contractures, and pain, Restorative Nursing Manager U and MDS Nurse H indicated they understood but did not provide further explanation. Documentation of Resident #36's ROM evaluations and assessments as well as facility policy/procedure pertaining to nursing staff completion and documentation of ROM were requested from Restorative Nursing Manager U at this time. On 3/11/20 at 4:01 PM, observation occurred of Resident #36 in their room. The Resident was in bed and wearing a hospital gown in the position as previously observed. On 3/12/20 at 10:48 AM, the facility Administrator provided documentation of Resident ROM documentation. Review of requested documentation did not include any information/documentation for Resident #36. An interview was conducted with Therapy Director V on 3/12/20 at 2:43 PM. When queried regarding Resident #36, Therapy Director V reviewed the medical record and stated, (Resident #36) was never evaled (by therapy). They came into facility on Hospice. No further explanation was provided. Resident #45 On 3/11/20 at 1:55 PM, Resident #45 was observed in their room, sitting in a geri-chair. Both of the Resident's feet were pointed straight down with their ankles at a 180-degree angle and the Resident's right hand was positioned in a fist. An interview was completed with the Resident at this time. When asked if they could open their right hand, Resident #45 opened their hand slightly, without fully extending their fingers and stated, It hurts. When the Resident opened their right hand, the right pointer finger was noted to be bent at the first joint towards the other fingers on their right hand. When asked if they were able to move their ankles, Resident #45 revealed they could not and were unable to walk. Record review revealed Resident #45 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the Resident was severely cognitively impaired and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident had impaired range of motion on one side of their lower extremities. Review of Resident #45's care plans revealed the Resident did not have a current care plan in place for restorative nursing services. An interview was conducted with Restorative Nursing Manager U and MDS Nurse H on 3/11/20 at 3:20 PM. When queried regarding Resident #45's ROM and if they were receiving restorative nursing services, Restorative Manager U reviewed the Resident's medical record and stated, Previously on restorative until July 2019. Restorative Nursing Manager U and MDS Nurse H further indicated the Resident had not received restorative nursing services since that time. Documentation of Resident #45's ROM evaluations/assessments and any restorative documentation were requested from Restorative Nursing Manager U at this time. On 3/12/20 at 10:48 AM, the facility Administrator provided Resident ROM documentation. Review of requested documentation did not include any information/documentation for Resident #45. An interview was conducted with Therapy Director V on 3/12/20 at 2:43 PM. When queried regarding Resident #45, Therapy Director V reviewed the medical record and stated, Last time on therapy was September 2019. With further inquiry, Therapy Director V revealed the Resident was seen by therapy at that time for positioning. When queried regarding the Resident's ROM limitations at that time, Therapy Director V stated, RLE and LLE impaired. When asked if the Resident was referred to restorative nursing following therapy completion, Therapy Director V indicated the Resident was admitted to Hospice care. Review of provided Resident #45's Physical Therapy Evaluation and Plan of Treatment documentation revealed the following: -Start of Care Date: 9/10/19: Musculoskeletal System Assessment . RLE ROM = Impaired; LLE = Impaired . RLE ROM . Knee = Impaired (15 degree knee flexion); Ankle = Impaired . LLE ROM . Knee = Impaired (0 degree flexion, patient keeps knee stiff); Ankle = Impaired . Functional Limitations Present d/t (due to) contracture = Yes . BLE Ankle PF (Plantar Flexion- foot drop) contracture . An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 3:35 PM. When queried regarding Resident #58 developing contractures within the facility and being discharged from restorative nursing services with Health Care provider documentation in December 2019 indicating stiffness vs contracture, the DON stated, We follow the recommendations from therapy pertaining to length of time Resident's receive restorative services. No further explanation was provided. When queried regarding Resident #45 and 48's limitations in ROM, documentation of decrease in ROM between therapy evaluation and MDS, and lack of documentation of ROM and/or implementation of restorative nursing, the DON did not provide further explanation. Restorative nursing documentation for Resident #58 was requested on 3/11/20 at 3:26 PM but not received by the conclusion of the survey. Review of facility policy/procedure entitled, Establishing a Restorative Nursing Program (No Date) revealed, Identifying Residents for the Program . Residents who could benefit from receiving Nursing Restorative Care can be identified in the following ways: On admission, From information on the MDS . Who is Responsible to Identify Residents for the Program? All staff has the responsibility . Admission Guidelines to Restorative Care . Those who are ready to finish a skilled nursing program . Residents who should receive skilled rehabilitation therapy services but is not strong enough . Residents who require minimal to moderate assistance . Residents who require supervision at mealtimes . Those who could do better working with one-on-one staff .
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** Deficient Practice Statement One: Based on observation, interview and record review, the facility failed to implement planned interventions to prevent falls for one (#36) of three Residents reviewed for falls, resulting in lack of implementation of interventions following falls and the potential for additional falls and falls with injury. Findings include: On 3/10/20 at 11:14 AM, Resident #36 was observed in their room. The Resident was laying in bed, positioned on their back. The Resident did not respond verbally or non-verbally when asked questions. A fall mat was positioned on the floor on the left side of the Resident's bed, toward the door of the room. A second fall mat was noted directly under the bed. Record review revealed Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 1/10/20, revealed the Resident was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living (ADLs). Review of Resident #36's care plan revealed a care plan, I am at risk for falls r/t (related to) [MEDICAL CONDITION] OR [MEDICAL CONDITION]. I have a history of falls r/t Dementia, [MEDICAL CONDITION], Psychoactive drug use, [MEDICAL CONDITION] Disorder, Unaware of safety needs, Vision/hearing problems and Communication Barrier. I am a high risk for falls r/t anxiety and agitation (Initiated: 10/30/19; Revised: 11/24/19). The care plan included the intervention, Bilateral Floor Mats on both sides of my bed (Initiated: 10/30/19). On 3/11/20 at 10:05 AM and 1:06 PM, Resident #36 was observed in their room in bed. At both observations, one fall mat was in place on the left side of the Resident's bed, towards the door of the room and a second fall mat directly under the Resident's bed. Record review revealed Resident #36 fell within the facility on 10/30/19, 11/23/19, and 11/29/19. Resident #36's progress note documentation in the medical record revealed the following: -10/30/19 at 8:40 PM: Incident Note . Resident observed on the floor laying on right side. Assessed resident noted redness on right side head temporal area and right cheek area. Neuro checks performed and found within normal limits of residents condition. Floor mat placed at bedside . ordered skull x ray and facial x ray ordered, Concave mattress ordered, and [MEDICATION NAME] (anti-anxiety medication) increased to Q

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) (every) 6 hrs PRN (as needed) for increased agitation. Tylenol and [MEDICATION NAME] given . -11/23/19 at 4:56 PM: Incident Note . Resident observed laying on floor on left side. Resident was re- positioned multiple times during day shift due to resident being anxious/agitated. Resident was also medicated as ordered. Resident was positioned on left side and grabbed top of concave mattress and pulled self causing mattress to turn . Resident assessed and noted palpable mass on left forehead along with Left eye swelling and left elbow swelling. Neuro checks performed within normal limits to residents ability . Noted grimaces upon touch . New orders to give Tylenol for pain, STAT skull/facial X-ray and Left elbow, discontinue concave air mattress and replace with regular concave mattress and bilateral floor mats. Cold pack also ordered for swelling . -11/29/19 at 3:21 PM: Incident Note Late Entry . Resident observed on the floor on floor mat . Resident placed on Q (every) 1 hr checks until mattress is delivered . On 3/11/20 at 4:00 PM, Resident #36 was observed in their room in bed. One fall mat was in place on the left side of the Resident's bed, towards the door of the room and a second fall mat was directly under the Resident's bed. An interview was conducted with Unit Manager Licensed Practical Nurse (LPN) G. When queried regarding Resident #36's fall risk and falls within the facility, Unit Manager LPN G indicated the Resident had fell while in the facility and stated, (Resident #36) is a real high fall risk. When asked how many fall mats Resident #36 is supposed to have in place for fall prevention interventions, Unit Manager LPN G stated, Should be two. An observation of Resident #36 in their room was completed with Unit Manager LPN G at this time. The fall mats remained in the same position as previous observations. When queried regarding the fall mat being under the bed, Unit Manager LPN G revealed the mat was supposed to be on the side of the Resident's bed, not under it. When queried regarding multiple observations of the fall mat being under the bed, Unit Manager LPN G was unable to provide an explanation and moved the fall mat from under the bed to the right side of the Resident's bed. Review of facility provided Incident and Accident Reports revealed the following: -10/30/19: 5:50 PM . Resident Room . Incident Type: Fall . Brief Description: Resident observed on floor laying on right side . Injury Type . Abrasion . Bruise (diagram indicate right side of head) . New Action Taken to Prevent Reoccurrence . Floor mat . Care plan updated . Concave mattress . -11/23/19: 3:15 PM . Resident Room . Incident Type: Fall . Brief Description: Resident observed on floor laying on left side . Injury Type . Bruise/Hematoma - Left forehead . Swelling left eye . left elbow . New Action Taken to Prevent Reoccurrence . Floor mat . Regular Concave Mattress . -11/29/19: 3:21 PM . Resident Room . Incident Type: Fall . Brief Description: Resident observed on floor laying on the floor . New Action Taken to Prevent Reoccurrence . One hour checks until new mattress arrives . An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 3:33 PM. When queried regarding Resident #36's falls within the facility, interventions following the falls on 10/30/19 and 11/23/19 both indicating fall mats were implemented as new interventions, and multiple observations of one fall mat being directly under the Resident's bed, the DON stated, I don't know why like that. No further explanation was provided. Review of facility policy/procedure entitled, Fall Management Guidelines (No Date) revealed, Each resident is assisted in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices . to minimize the risk for falls . A plan of care is developed and implemented based on this evaluation with ongoing review . Practice Guidelines . 2. Residents identified at risk for falls will have a care plan developed and implement fall prevention interventions as needed based on their assessment .The IDT (interdisciplinary) will review/modify the plan of care to minimize the risk of repeat falls . Deficient Practice Statement 2 Based on observation, interview and record review, the facility failed to identify, implement, and ensure a safe environment for one resident (R314) of one reviewed for potential accidents by leaving a running fan on the resident's bed resulting in the potential for fire hazard and injury to resident. Findings include: On 3/10/20 at 2:44 PM, R314 was observed in bed with a dressing to the right lower leg. A box fan was observed on the bed running at high speed. There was also bed linen around the bottom of the fan. A review of the electronic medical record noted R314 was admitted to the facility on [DATE] with a right fibula fracture (ankle fracture) status [REDACTED]. The baseline care plan did not address resident safety. On 3/11/20 at 9:02 AM, R314 was observed sitting in a wheelchair. The box fan remained in the same area running at high speed. On 3/11/20 at 12:07 PM, the box fan continued in the same area running at high speed. R314 was not in the room. On 3/11/20 at 3:10 PM, the box fan continued in the same area running at high speed. The Director of Nursing (DON) was interviewed, shown and queried about the fan on R314's bed. The DON said, This is a problem. The fan should not be on the bed. This is dangerous. The staff should have placed the fan on a nightstand. A review of the facility's Unusual Occurrence policy which was undated outlined the following, The facility will take the measures necessary to provide residents, staff and visitors with a safe and incident free environment .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide catheter care and maintain urinary catheters in a sanitary manner affecting three residents (R38, 45, and 419) of four residents reviewed for urinary catheters resulting in the likelihood of the preventable spread of infections. Findings include: R419 On 03/10/20 at 1:36 PM, R419 was observed in a wheel chair in the hall and a urinary catheter drainage bag was observed lying on the floor beneath the wheel chair. An attempt to interview R419 was made but R419 did not make eye contact or respond to any questions. On 03/11/20 at 6:40 AM, R419 was observed lying in bed with eye closed in bed and the urinary catheter drainage bag was partially lying on the floor. At 12:19 PM, R419 was again lying in bed with eyes closed in bed and the urinary catheter drainage bag remained partially lying on the floor. On 03/12/20 at 09:30 AM, Certified Nurses Aide (CNA P) was asked about R419's catheter and stated, I've never seen (R419) touching or playing with the cath. It should not be touching the floor because that is unsanitary. It must have been the Aide that day. Record review of R419's Electronic Health Record (EHR) revealed R419 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A recent Minimum Data Set (MDS) assessment dated [DATE] revealed R419 had a Brief Interview for Mental Status (BIMS) score of three indicating a severely impaired cognition and needed extensive assistance with Activities of Daily Living (ADLs) including toileting. Resident #38 On 3/10/20 at 11:52 AM, an observation and interview occurred with Resident #38 in their room. The Resident was in bed, positioned on their back. An indwelling urinary catheter drainage bag was observed on the right side of the bed. The urine in the drainage tubing had a purulent appearance and was dark, creamy tan in color. The urine was not draining through the tubing and was visibility [MEDICATION NAME] in consistency with sediment. The catheter drainage bag was positioned directly on the floor. Significant amounts of observable dirt and debris were noted on the floor of the Resident's room, including the area of the room where the Resident's catheter drainage bag was positioned directly on the floor. An open and uncovered syringe and container were present on the windowsill of the room, near the Resident's bed. The syringe and container were labeled as (Resident #38 room/bed) Cath flush. When queried regarding their indwelling urinary catheter, Resident #38 indicated they had had the catheter for years. When asked if they had any recent Urinary Tract Infections (UTIs) and staff care of the catheter, Resident #38 revealed they were unsure. Record review revealed Resident #38 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident had an indwelling urinary catheter. Review of Resident #38's care plans revealed the care plan, I have a 18 French Foley catheter r/t (related to) hidradenitis suppurativa to left and right buttock, contractures, Steven-Johnso[DIAGNOSES REDACTED] (Initiated: 1/5/17; Revised: 5/18/19). The care plan included the interventions: -Catheter: I have a catheter, please position my catheter bag and tubing below the level of my bladder and away from entrance room door. Provide me with a leg strap and use a dignity bag to cover my catheter bag (Initiated: 1/5/17) -Observe me for any s/s (signs/symptoms) of UTI (Urinary Tract Infection) such as pain, burning, blood tinged urine, cloudiness, no output, darkening of urine color, increased pulse, increased temp, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, and report (Initiated: 1/5/17) -Please provide me with Foley catheter care every shift and as needed (Initiated: 1/5/17) On 3/11/20 at 3:00 PM, Resident #38 was observed in their room, positioned on their back in bed. The Resident's urinary catheter drainage bag was on the right side of the bed, positioned directly on the floor. An observation of Nursing Assistant E emptying Resident #38's indwelling urinary catheter drainage bag occurred on 3/11/20 at 3:10 PM. Upon entering the room, the Resident's catheter drainage bag was noted to be positioned directly on the floor. When queried regarding the catheter drainage bag on the floor, Nursing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Assistant E raised the Resident's bed but did not provide an explanation. The urine emptied from Resident #38's urinary catheter drainage bag was very dark amber in color with formidable amounts of sediment. The odor of the urine was exceptionally foul and odorous which infiltrated the area surrounding the exposed urine. Resident #45 On 3/10/20 at 3:02 PM, an observation occurred of Resident #45 in their room, sitting in a geri-chair (large, reclining, wheeled chair frequently utilized for individuals with severe limitations in mobility and/or positioning needs). The Resident had an a indwelling urinary catheter in place. The urine in the drainage tubing was dark amber in color and was thick in composition with a significant amount of visible sediment. The indwelling urinary catheter drainage bag was positioned directly on the floor. When queried how long they had had a urinary catheter, the Resident was unable to recall. Record review revealed Resident #45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the Resident was severely cognitively impaired and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident had an indwelling urinary catheter. Review of Resident #45's care plans revealed the Resident had two active care plans with the focus, I have a 16fr (french) Foley catheter r/t (related to) [MEDICAL CONDITION] bladder (Initiated: 2/8/19; Revised: 7/8/19). The care plans included the interventions: -Catheter: I have a catheter, please position my catheter bag and tubing below the level of my bladder and away from entrance room door. Provide me with a leg strap and use a dignity bag to cover my catheter bag (Revised: 7/8/19) -Change my Foley cath and bad (bag) monthly and as needed (Revised: 2/9/20) -Ensure proper Foley cath care is rendered Q (every) Shift and PRN (as needed) (Revised: 2/9/19) -Observe me for any s/s (signs/symptoms) of UTI (Urinary Tract Infection) such as pain, burning, blood tinged urine, cloudiness, no output, darkening of urine color, increased pulse, increased temp, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, and report (Initiated: 7/8/19) On 3/11/20 at 1:55 PM, Resident #45 was observed in their room, sitting in a geri-chair. Their catheter drainage bag was uncovered and visible from the hall of the facility. The urine in the tubing and drainage bag was dark amber in color with a large amount of visible sediment. An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 11:45 AM. When queried if urinary catheter drainage bags should be positioned directly on the floor, the DON replied, Should not be on floor. When queried regarding observations of Resident #38 and 45's urinary catheters including observations of the urine, the DON stated, Shouldn't be like that. With further inquiry, the DON revealed catheters are changed monthly and as needed. When asked if the conditions observed would constitute changing the catheter, the DON did not provide a response. When queried regarding observation of the syringe and container labeled to flush Resident #38's catheter sitting, uncovered on the windowsill in their room, the DON revealed that was not the appropriate place, per facility policy/procedure to store the equipment. Review of the facility's undated policy and procedure, Indwelling Catheter Care did not include information pertaining to urinary catheter drainage bags being placed directly on the floor.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize policies and procedures to ensure tube feeding administration per planned interventions and tube feeding equipment was maintained in a clean and sanitary manner for six (#'s 36, 54, 419, 25, 26, and 18) of six Residents reviewed for tube feeding, resulting in lack of implementation of planned interventions, unsanitary and unclean tube feeding equipment and pumps. Findings include: Resident #36 On 3/10/20 at 11:16 AM, Resident #36 was observed in their room. The Resident was laying in bed, positioned on their back. A tube feeding pump with tube feeding solution, dated 3/9; 6 PM was in place and connected to the Resident's. The tube feeding pump was off and not infusing. The tube feeding pump and pole were visibly soiled with significant amounts of various colored, unknown substances. The Resident did not respond verbally or non-verbally when asked questions. Record review revealed Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 1/10/20, revealed the Resident was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living (ADLs). Review of Resident #36's medical record revealed a care plan with the focus, I am dependent upon tube feeding . (Initiated: 10/4/19; Revised: 10/19/19). The care plan included the intervention, I need my HOB (Head of Bed) elevated 45 degrees during and thirty minutes after tube feed (Initiated: 10/4/19). On 3/11/20 at 10:05 AM, Resident #36 was observed in their room. The Resident was laying in bed, positioned on their back. The head of the Resident's bed was elevated 20 to 25 degrees and they were receiving tube feeding via pump at 60 milliliters (mL) per hour. The tube feeding pump and pole remained visibly soiled with significant amounts of various colored, unknown substances. An observation of Resident #36 was conducted with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 3/12/20 at 9:10 AM. Upon entering the Resident's room, the ADON and DON were queried regarding Resident #36's tube feeding pump and pole being visibly soiled, the ADON stated, No, that shouldn't be dirty. The DON indicated they would address the unclean equipment with staff. An interview was conducted with Unit Manager Licensed Practical Nurse (LPN) G on 3/12/20 at 12:33 PM. When queried regarding facility policy/procedure pertaining to tube feeding and head of bed elevation, Unit Manager LPN G revealed the head of the bed should be elevated between 30 to 45 degrees. When queried regarding observation of Resident's #36's head of their bed being less than 30 degrees while receiving tube feeding, Unit Manager LPN G was unable to provide an explanation. R419 On 03/10/20 at 11:05 AM, R419 was not in the room and the room was being mopped by a housekeeper. R419 was observed sitting in a wheel chair in the hall, did not make eye contact or reply to any questions, and a urinary catheter drainage bag was lying on the floor under the wheelchair. Also observed was a Percutaneous Endoscopic Gastrostomy tube (PEG, for tube feedings) hanging in between the resident's shirt and pants. On 03/10/20 at 11:19 AM, R419's room was observed and a tube feeding pump mounted on a rolling pole was noted to have dried on tube feeding formula on the top of the feeding pump, on the base of the pole, and on the floor between the pole and the bed. On 03/11/20 at 12:16 PM, R419's tube feeding pump, tube feeding pole base, and floor remain soiled with dried on tube feeding formula. Review of R419's Electronic Health Record (EHR) revealed, R419 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A recent Minimum Data Set (MDS) assessment dated [DATE] revealed R419 had a Brief Interview for Mental Status (BIMS) score of three indicating a severely impaired cognition and needed extensive assistance with Activities of Daily Living (ADLs). R54 On 03/10/20 at 11:29 AM, R54 was greeted and stated, It's a pleasure to meet you. It was observed that R54 had a tube feeding pump in the corner of the room. A large amount of dried on tube feeding formula was observed on the top of the tube feeding pump and the base of the tube feeding pump's pole had multiple areas of dried on tube feeding formula. R54 was asked about the tube feeding pump and stated, They clean it about every week, they use it at night. Record review of R54's Electronic Health Record (EHR) revealed R54 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A recent MDS dated , 01/24/20 revealed R54 had a BIMS score of 13 indicating an intact cognition and needed extensive assistance with ADLs including eating. On 03/11/20 at 1:12 PM, Certified Nurses Aide (CNA)R was asked about maintaining the cleanliness of the tube feeding pumps and poles and stated, I'm not sure, but I think it's housekeeping's job. On 03/11/20 at 1:15 PM, Nurse N was asked about maintaining the cleanliness of the tube feeding pump and poles and stated, It's housekeeping's job to clean the pumps and poles. On 03/12/19 at 8:21 AM, CNA C was asked about maintaining the cleanliness of the tube feeding pumps and poles and stated, I don't really know. On 03/12/20 at 8:38 AM, Unit Manager, Nurse G was asked about the facility's policy and procedure regarding maintaining tube feeding pumps and poles in a sanitary manner and stated, I've worked here for [AGE] years and it's always been midnight's job. Anyone can clean them though. On 03/12/20 at 2:50 PM, the Director of Nursing (DON) was asked about the facility's policy and procedure regarding the cleanliness of the tube feeding pumps and poles and stated, There doesn't need to be a policy and procedure for that. If it's hung right it wont leak. R25 On 3/10/20 at 11:17 AM, R25 was observed in bed with their tube feeding connected. The tube feeding pump was observed to have dried tube feeding formula covering the top of the pump. In addition, the base of the pole and the floor was observed to have dried tube feeding formula. On 3/11/20 at 12:13 PM, R25 was observed in bed and the tube feeding pump, pole, and the floor continued to have areas of dried tube feeding formula. A review of the electronic medical record noted R25 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A review of R25's Minimum Data Set (MDS) noted that the Resident required total assistance with all activities of daily living care. R18 On 3/10/20 at 11:22 AM, R18 was

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	235491	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - ROSEVILLE	25375 KELLY RD ROSEVILLE, MI 48066

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) observed in bed. R18's tube feeding pump, tube feeding pole, and the floor was observed to have buildup of dried tube feeding formula. On 3/11/20 at 12:18 PM, R18 was observed in bed and the tube feeding pump, pole, and the floor continued to have areas of dried tube feeding formula. A review of the electronic medical record noted R18 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R18's Minimum Data Set (MDS) noted that the Resident required extensive assistance with activities of daily living care. R26 On 3/10/20 at 11:40 AM, R26 was observed in bed. Observed R26's tube feeding pump, tube feeding pole, and the floor with buildup of dried tube feeding formula. On 3/11/20 at 12:10 PM, R26 was observed in bed and the tube feeding pump, pole, and the floor continued to have areas of dried tube feeding formula. A review of the electronic medical record noted R18 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R18's Minimum Data Set (MDS) noted that the Resident required extensive assistance with activities of daily living care. On 3/12/20 at 9:55 AM, Nurse Manager K was interviewed and queried about R25, R18, and R26's tube feeding pumps, tube feeding poles, and the floors soiled with dried tube feeding formula. Nurse Manager K said, The nurses should clean the equipment. On 3/12/20 at 2:54 PM, The Director of Nursing (DON) was asked about the procedure of cleaning the tube feeding equipment and the dried formula on the floors. The DON said, The nurses are supposed to clean the pumps and poles daily. If the nurses spill formula on the floor they should clean it up. They have been trained. That's just lazy. Review of the facility's undated policy and procedure regarding tube feedings titled, Enteral Nutrition Guidelines revealed, 10. The nursing staff provides for routine cleaning of enteral feeding equipment.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain respiratory care equipment in a sanitary manner affecting two residents (R36 and 418) of four residents reviewed for respiratory care resulting in the likelihood of the preventable spread of infections. Finding include: R418 On 03/10/20 at 11:01 AM, R418 was observed lying in bed with eyes closed and did not respond for knocking, greetings, or the roommates loud TV. During the observation a oxygen concentrator was next to the bed and the nasal cannula (to deliver supplemental oxygen to the nostrils) was wrapped around the bottle of sterile water (to humidify the supplemental oxygen) and the tip of the nasal cannula was exposed. Also noted was a nebulizer (to deliver inhaled medications) and the nebulizer mask was lying in the top drawer uncovered. On 03/10/20 at 11:14 AM, Nurse S was asked about the facility's policy and procedure regarding the storage of respiratory care equipment and stated, They are PRN (as needed) and should be stored in a bag. Nurse S was then asked if R418 could use the respiratory equipment unassisted and stated, No. Record review of R418's Electronic Health Record (EHR) revealed R418 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A recent Minimum Data Set (MDS) assessment dated [DATE] revealed R418 had a BIMS (Brief Interview for Mental Status) score of 15 indicating an intact cognition and needed extensive assistance with Activities of Daily Living (ADLs). Resident #36 On 3/10/20 at 11:10 AM, Resident #36 was observed in their room in bed. The Resident positioned on their back and wearing a hospital gown. When spoke to, the Resident did not move nor open their eyes. The Resident had a tracheotomy and was receiving supplemental oxygen via a tracheotomy cuff/collar. The tracheotomy dressing was visibly soiled with an unknown substance. The oxygen administration and humidification tubing were directly on the floor. A suction machine was positioned next to the oxygen and humidification equipment on a dresser near the head of the Resident's bed. Suction tubing, with open and exposed suction equipment, were on top of the machine. Clear fluid was present in the suction machine canister and the canister was dated 2/28. Record review revealed Resident #36 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 1/10/20, revealed the Resident was rarely/never understood and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further revealed the Resident had received oxygen therapy, suctioning and tracheotomy care. Review of Resident #36's care plans revealed a care plan titled, I am at risk for altered respiratory status r/t (related to)[MEDICAL CONDITION] (Initiated: 10/4/19; Revised; 10/19/19). The care plan included the following intervention: -Oxygen Settings: 60% [MEDICAL CONDITION] at all times; oxygen @ 2 liters [MEDICAL CONDITION] PRN (as needed) for SPO2 (oxygen saturation) < 90% (Initiated: 10/4/19; Revised; 10/19/19). On 3/11/20 at 10:05 AM, Resident #36 was observed in their room. The Resident was laying in bed, positioned on their back. The Resident was dressed in a hospital gown and was receiving supplemental oxygen via tracheotomy collar. The oxygen tubing connected to the tracheotomy collar was positioned directly on the floor. At 9:00 AM on 3/12/20, observation occurred of Resident #36 in their room in bed. The Resident was receiving supplemental oxygen via tracheotomy collar. The oxygen tubing connected to the tracheotomy collar was positioned directly on the floor. An observation of Resident's #36 was conducted with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 3/12/20 at 9:10 AM. Upon entering the Resident's room, the ADON and DON were queried regarding Resident #36's tracheotomy oxygen supply tubing being positioned on the floor. Both the ADON and DON stated, Shouldn't be on floor. The ADON then indicated they were going to obtain new tubing for the Resident's oxygen. When queried regarding observation of the suction equipment including the date on the canister, both the ADON and DON revealed respiratory equipment should be changed every seven days per facility policy/procedure. Review of facility policy/procedure entitled, Tracheotomy Tube (no date) revealed, Policy: It is the policy of this facility to provide tracheotomy care according to standards of practice . The policy did not address oxygen administration and equipment management for tracheotomies. Review of the facility's undated policy and procedure regarding respiratory care equipment titled, Respiratory Equipment & Handling of revealed, Policy It is the policy of this facility to maintain respiratory equipment in a clean and sanitary manner . Empty intermittently used nebulizers after use and rinse with tap water, shake dry and place on a clean paper towel to air dry. After drying, place in a plastic bag, which is then hung from the flow meter .

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 operationalize policies and procedures to coordinate [MEDICAL TREATMENT] care for one (#64) of one Resident reviewed for [MEDICAL TREATMENT], resulting in lack of communication, care coordination, and assessment of a central port utilized for [MEDICAL TREATMENT] and the likelihood for infection. Findings include: On 3/10/20 at 11:05 AM, Resident #64 was not present in their room. When queried regarding the Resident's location, Licensed Practical Nurse (LPN) X revealed the Resident was supposed to have [MEDICAL TREATMENT] but were unsure if they had gone. Record review revealed Resident #64 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to extensive assistance to perform Activities of Daily Living (ADLs). The MDS did not indicate the Resident was receiving [MEDICAL TREATMENT]. Review of Resident #64's care plans revealed a care plan entitled, I need [MEDICAL TREATMENT] r/t (related to) [MEDICAL CONDITION] (Initiated: 7/23/19; Revised: 7/31/19). The only intervention included in the care plan detailed, Auscultate/palpate my shunt for a thrill and bruit each shift. (Initiated: 7/23/19). An interview was conducted with Unit Manager LPN G on 3/12/20 at 8:56 AM. When queried regarding Resident #64's [MEDICAL TREATMENT] treatments, Unit Manager LPN G revealed Resident #64 has [MEDICAL TREATMENT] on Tuesdays, Thursdays, and Saturday. Unit Manager LPN G then stated, (Resident #64) refused today. (The Resident) refuses sometimes. When queried the method in which the Resident receives [MEDICAL TREATMENT] treatments, via shunt or Central Venous Catheter (CVC), Unit Manager LPN G stated, (Resident #64) has a cath. They used to have a shunt, but it was disconnected. When asked if Resident #64 had a shunt since they were admitted to the facility, Unit Manager LPN G replied, (The Resident) has not had a shunt since they have been here- period. On 3/12/20 at 11:53 AM, Resident #64 was observed in their room, in bed. When queried regarding [MEDICAL TREATMENT], Resident's #64 revealed they did not go to [MEDICAL TREATMENT] today because they were waiting to go to the dentist. When asked how they received [MEDICAL TREATMENT], Resident #64 revealed a double lumen central line on their right chest wall. The insertion site was covered with an undated, non-transparent gauze and [MEDICATION NAME] dressing. When queried regarding care of the central line, including dressing changes, Resident #64 revealed facility staff did not assess the CVC and/or change the dressing. An interview was completed with Unit Manager LPN G on 3/12/20 at 11:55 AM. When queried regarding facility policy/procedure pertaining to care of Resident #64's CVC for [MEDICAL TREATMENT], Unit Manager LPN G replied, We monitor the site for signs and symptoms of infection. When queried if the dressing covering the CVC line is changed and/or monitored by facility staff, Unit Manager LPN G stated, I don't know if (Resident #64) even has a dressing. With further inquiry regarding what was supposed to be in place and who was monitoring the site, Unit Manager LPN G reviewed the Resident's medical record and stated, No current order to monitor the cath (CVC). Review of Resident's #64's Medication Administration Record [REDACTED]. When queried regarding the Resident's care plan for [MEDICAL TREATMENT] including one intervention pertaining to assessment and monitoring of a [MEDICAL TREATMENT] shunt when the Resident did not have a shunt, Unit Manager LPN G stated, I agree. They can't. From day one, (Resident #64) never had a shunt. Unit Manager LPN G then stated, I have to work the cart sometimes and I have never gotten (Resident #64) back from [MEDICAL TREATMENT] with a dressing on their (CVC site). When asked who is responsible for changing the dressing and monitoring the CVC site, Unit Manager LPN G stated, They (facility staff) need to check that site. Unit Manager LPN G further revealed they were going to contact the Resident's [MEDICAL TREATMENT] center for confirmation and clarification pertaining to the CVC line site and care. A policy/procedure pertaining to coordination of care for Residents receiving [MEDICAL TREATMENT] was requested at this time. An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 3:35 PM. When queried regarding Resident #64's [MEDICAL TREATMENT] port including lack of orders for care and assessment, the DON did not provide an explanation. A policy/procedure pertaining to coordination of [MEDICAL TREATMENT] care was requested on 3/12/20 but not received by the conclusion of the survey.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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** Based on interview and record review the facility failed to provide adequate staffing for two sampled residents (R73 and

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) R103) and seven confidential group residents, resulting in lack of timely incontinence care and overall resident verbalization of dissatisfaction with care. Findings include: R73 On 3/10/20 at 10:48 AM, during an initial tour of the facility, R73 was queried about staffing at the facility and stated, I wait two or three hours for a brief change, I wet myself frequently. R73 was asked how waiting to have their brief change made them feel, and stated, I feel like an animal. On 3/12/20 at 3:30 PM, R73 was further queried about staffing at the facility and stated, I have to sit in my own pee for hours. R73 indicated that this frequently occurs on the afternoon shift. R73 was asked how it made them feel and stated, Degraded. On 3/12/20 a review of R73's medical record was conducted and revealed the following, R73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R73's most recent Minimum Data Set Assessment ((MDS) dated [DATE], indicated that R73 was occasionally incontinent of Bowel/Bladder, had an intact cognition, and required extensive assistance of one person for toileting. During a Confidential Group meeting that was conducted in the facility on 3/10/20 at 4:12 PM, all seven residents who attended the meeting verbalized that there were not enough staff to meet their needs. Confidential R4 stated, I frequently lay in a wet brief. They don't change me. It makes me mad. On 3/11/20 at 1:19 PM, Certified Nursing Assistant (CNA) O was queried about staffing at the facility and stated, It's horrible, we are assigned fourteen to eighteen residents everyday. That's too much for one person. I feel overwhelmed. On 3/12/20 at 9:52 AM, CNA W was queried about staffing at the facility and stated, Sometimes I feel overwhelmed. On 3/12/20 at 9:55 AM, Nurse Manager (NM) K was queried about staffing at the facility and stated, We need a lot more staff, patient acuity is high. R103 On 3/12/20 at 11:20 AM, R103 was met in their room for observation and interview. R103 stated, I've been waiting since 9:00 AM, for someone to change me, I stink. R103 indicated that they had defecated in their brief. R103 was queried on if they had activated their call light. R103 smiled and stated, Three CNAs came in here and told me that they didn't have time to help me. On 3/12/20 a review of R103's medical record was conducted and revealed the following, R103 was admitted to the facility with a [DIAGNOSES REDACTED]. On 3/12/20 at 2:45 PM, the Director of Nursing (DON) was queried about their expectations for staff when responding to residents needs and answering call lights. The DON stated, I expect staff to answer call lights in a timely manner. Staff should acknowledge the light and the resident. The DON indicated that staff should give the resident a time frame for when they are coming back to assist them. The DON indicated that anyone at the facility can answer a call light. On 3/12/20 at 3:58 PM, the Administrator was queried about expectations for staff when responding to residents needs and answering call lights. The Administrator indicated that staff should be following the facility policy for answering call lights. They further indicated that anyone at the facility can answer a call light and then get appropriate assistance as needed depending upon the need of the resident. Review of the facility's staff sign-in sheets for the weekend prior to the survey revealed, on Friday March 6, 2020 the day shift Certified Nurses Aides (CNAs) were assigned to 16 residents each to care for, the afternoon shift CNA's were assigned to care for 23 residents each, and the midnight shift CNAs were assigned to care for 28.75 residents each. On 03/12/20 at 2:00 PM, the DON was asked about the CNA to resident ratio and stated, Not everyone signs in on those sheets. The DON was asked if there were time card printouts and stated, Yes. Review of the time card printouts revealed, on Friday March 6, 2020 the day and afternoon shift CNAs were assigned to care for 14 residents each and the midnight shift CNAs were assigned to care for 23 residents each. On Saturday March 7th, the day and afternoon shift CNAs were assigned to care for 16 residents each, and the midnight shift CNAs were assigned to care for 14 residents each. On Sunday March 8th, the day and afternoon shift CNAs were assigned to care for 14 residents each, and the midnight shift CNAs were assigned to 19 residents each. On Monday March 9th, the day shift CNAs were assigned to care for 12 residents each, the afternoon shift CNAs were assigned to care for 19 residents each, and the midnight CNAs were assigned to care for 12 residents each. On 3/12/20, facility policies titled, Staff Schedule Review with no date and Daily Unit Rounds with no date, were reviewed. Neither policy defined staffing requirements for resident needs and did not define timely call light response.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on interview and record review, the facility failed to display daily nurse staffing information on a timely basis and maintain 18 months of the daily nurse staff postings, affecting all residents and visitors in the facility resulting in necessary staffing information not being readily available to residents and visitors. Findings include: On 03/12/20 at 1:19 PM, the facility was asked to provide 18 months of daily nurse staffing postings and provided one folder and one binder containing daily nurse staffing postings. Further review of the documents revealed that only nine months, of daily nurse staffing postings were retained in 2019. For January 2020 the daily nurse staffing posting dates retained were the 30th and 31st. For February 2020, only the 3rd, 4th, 5th, 10th, 18th, 25th,and 27th were retained. For March 2020, only the 6th, 9th, were retained and the March 10 nurse staffing posting was not posted until 1:42 PM, on 03/10/20 and March 11th was still posted on 03/12/20. On 03/12/20 at 2:52 PM the Director of Nursing (DON) was asked about the facility's policy and procedure regarding the daily nurse staffing postings and stated, I just hired a new staffing coordinator. I know they should be posted but I just didn't get to it. The DON was asked about retaining 18 months of the posting and stated, I have to look for more. No further daily nurse staffing postings were presented. The DON was asked for the facility's policy and procedure regarding daily nurse staffing postings and it was not submitted by the end of the survey.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow timely documentation of narcotic medication administration per physician order for [REDACTED]. Findings include: On 3/11/20 at 10:05 AM, R55 was observed in bed watching television. R55 was interviewed regarding their stay at the facility. R55 stated that they did not receive their [MEDICATION NAME] (Narcotic) medication on time and also missed shifts and days without their [MEDICATION NAME]. R55 said, I can always tell when I don't get my [MEDICATION NAME]. I also used heroin in the past. I need my medication. When I missed doses, my whole body hurts so bad. A review of the electronic medical record noted R55 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R55's Minimum Data Set (MDS) noted that the Resident required extensive assistance with activities of daily living. The care plan initiated on 7/31/19 noted the following: Anticipate and meet my needs .Administer my [MEDICATION NAME] medications as ordered by my physician. A review of the medication order by Physician T noted the following: [MEDICATION NAME] 10mg (milligrams) give two tablet by mouth two times a day every 12 hours every day for chronic pain. A review of the Medication Administration Record (MAR) noted the following dates of missing [MEDICATION NAME] doses: 9/4/19: 6AM dose 9/16/19: 6AM dose 9/20/19: 6AM dose 9/24/19: 6AM dose 9/27/19: 6PM dose 9/28/19: 6PM dose 10/14/19: 6PM dose 12/17/19: 6AM dose 1/10/20: 6AM dose 2/21/20: 5AM dose and 8PM dose 2/22/20: 5AM dose 2/28/20: 5AM dose 2/29/20: 8PM dose 3/1/20: 5AM dose 3/6/20: 8PM dose 3/7/20: 5AM dose On 3/12/20 at 10:46 AM, Nurse Manager K was interviewed and queried about the missing [MEDICATION NAME] doses regarding R55. Upon review of the Controlled Substance Proof of Use Log, it showed that the [MEDICATION NAME] was signed out. However, the doses were not documented in R55's MAR that the dose was actually administered. In addition, Nurse Manager K was not able to locate all dates of the Controlled Substance Proof of Use Log. On 3/12/20 at 11:06 AM, The Director of Nursing (DON) was interviewed and queried about the missing doses of [MEDICATION NAME]. The DON said, I think (R55) is upset because (they) are not receiving the same dose of [MEDICATION NAME] prior to admission. It's obvious that (R55) received the [MEDICATION NAME] because it was signed out. The nurses must have forgotten to sign the MAR. I've in-serviced them about documentation. The policy General Dose Preparation and Medication Administration dated and revised on 1/1/13 noted the following: During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Document the administration of controlled substances in accordance with applicable law . After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms.

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	235491	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - ROSEVILLE	25375 KELLY RD ROSEVILLE, MI 48066

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9)
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 interview and record review, the facility failed to ensure that a resident who was prescribed anti-anxiety medication had adequate documentation to justify use beyond 14 days for prn (as needed) medication, for one (R417) of six sampled residents reviewed for unnecessary medication use, resulting in the potential for unnecessary medication, serious side effects and adverse reactions, and the inability to monitor the effectiveness of the prescribed treatment due to lack of documented supporting evidence. Findings include: On 03/10/20 at 11:00 AM, R417 was interviewed regarding the care received at the facility and answered all questions with incomprehensible responses. Record review of R417's Electronic Health Record (EHR) revealed that R417 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven indicating a severely impaired cognition and R417 needed extensive assistance with Activities of Daily Living (ADLs). MDS section E, for behaviors indicated that R417 did not display any aggressive behaviors at the time of the assessment. Review of R417's medication orders revealed an order written [REDACTED].*Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for anxiety. The scheduling detail indicated Indefinite. Review of R417's current Medication Administration Record [REDACTED]. On 03/12/20 at 1:00 PM, Nurse N was asked about R417's order for [MEDICATION NAME] and stated, I haven't had to give (R417) any, (R417) been pretty calm even when I've worked other shifts. On 03/12/20 at 2:47 PM, the Director of Nursing (DON) was asked about the facility's policy and procedure regarding PRN anti-anxiolytic medications and stated, They should have 14 day stop date. The facility's policy and procedure regarding PRN anti-anxiolytics was requested but not received by the end of the survey.
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 observation and record review 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 Protectives 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 all facility occupants in the event of a fire. Findings Include: (1) On August 25, 2020 at 11:00 AM, observation revealed the fire-rating label on the fire-rated door framed to the Basement Wheel Chair Room was obstructed by paint and unreadable. (2) On August 25, 2020 at 11:40 AM, record review revealed the facility failed to make readily available documentation of their Fire Rated Doors Annual Inspection for the last calendar year. These findings were discussed in interview view with the Facility Maintenance Director and the Assistant Maintenance Director at the time of discovery.
F 0868 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**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 that Quality Assessment and Assurance meetings were held quarterly, resulting in the potential for delayed resolution of facility issues with the potential to affect all residents residing at the facility. Findings include: On 3/12/20 at 11:00 AM, a meeting was held with the Administrator to review Quality Assurance (QA) activities at the facility. A review of the QA meeting sign in sheets for the months of July 2019 through January 2020, revealed that the sign in sheets were missing and that there was no indication that QA meetings had been conducted during those months. On 3/12/20 at 11:15 AM, the Administrator was queried on the missing QA sign in sheets and stated, We don't have them. On 3/12/20 a facility policy titled Quality Assurance Performance Improvement (QAPI) Reviewed and/or Revised 2/17/20 was reviewed and stated the following, Policy, The QAPI Committee meets at least quarterly to identify issues requiring quality assessment and/or quality assessment action.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary, homelike environment, in resident rooms, bathrooms, shower rooms and hallways, resulting in the increased potential for cross contamination, accidents, and the potential for resident dissatisfaction with their living conditions. Findings include: On 3/9/20 between 10:00 AM-11:00 AM, during observation of the facility, the following items were observed: 1. In the hallway outside rooms 218/219, there were ceiling tiles stained and discolored with a black, mold-like substance, from previous water damage. On 3/9/20 at 3:00 PM, when queried, Maintenance Supervisor Q stated it was from condensation, and that he would get them changed. 2. In the second floor dining room, there was trash and food debris buildup inside the vent covers of the wall mounted heating units. On 3/9/20 at 3:05 PM, when queried, Maintenance Supervisor Q stated they would have to take them apart to clean inside. 3. The ice machine on the second floor was observed with dusty side vents and there was a buildup of trash and lids underneath. 4. In the halls throughout the second floor, there were numerous screws in the walls outside the resident rooms, which extended out from the wall approximately 1 inch. On 3/9/20 at 3:10 PM, when queried, Maintenance Supervisor Q stated They took down some art work, but they should have also removed the screws. 5. In the 2 North shower room, there were numerous cracked, missing floor tiles, and the floor drain cover was missing, leaving an open drain hole in the floor. In the toilet room connected to the 2 North shower room, there was a fabric covered chair sitting next to the toilet. The seat surface of the chair was heavily soiled with a thick layer of dried on feces. On 3/9/20 at 3:15 PM, when queried, Maintenance Supervisor Q stated That should have been put in the soiled utility room. 6. In the clean linen storage room, connected to the 2 North shower/toilet room, the floor was littered with trash, disposable gloves, and plastic silverware, and the ceiling vent cover was coated with dust. 7. In room [ROOM NUMBER], the glass globe on the wall mounted light fixture was observed to be broken, with jagged edges, and the bathroom ceiling exhaust vent cover was coated with dust. 8. In the hallway outside rooms 228/229, there was a fabric covered chair with dried on feces on the seating surface. 9. The flexible plastic sheet covering on the wall outside room [ROOM NUMBER] was pulled away from the wall, leaving a sharp, exposed edge. 10. The hand rails located in the hall outside room [ROOM NUMBER] was observed with one missing end cap, and one end cap that was cracked with exposed, sharp edges. 11. In the shared bathroom of room [ROOM NUMBER]/205, the bathroom ceiling exhaust vent was observed to be coated with dust. On 3/9/20 at 3:25 PM, when queried, Maintenance Supervisor Q stated housekeeping should be wiping them down. 12. In the 2 North shower/toilet room, the floor was littered with wheelchair foot rests, cardboard boxes and various resident equipment items, that were spilling out from inside the attached storage room. 13. In the second floor soiled utility room, there was a large, pile of wheelchair foot rests stacked on the counter and inside the sink basin. On 3/9/20 at 3:30 PM, when queried, Maintenance Supervisor Q confirmed that resident equipment should not be stored in the soiled utility room. 14. In the hallway outside rooms 106/107, there was a ceiling tile stained with a black, mold-like substance. 15. On the 1 South unit, there was an unlocked

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) toilet room, with no emergency call light system. When queried as to how a resident would call for help, if they used the bathroom and fell , Maintenance Supervisor stated, We're going to be getting a new call light system. I'm not sure if that room will be included. 16. In the first floor therapy room, the ceiling ventilation cover was observed with a dusty, web-like covering. 17. In the shared bathroom of rooms 138/139, the bathroom ceiling vent cover was coated with dust. 18. In the shared bathroom of rooms 117/118, the fluorescent light fixture cover was missing, and there was no protective covering for the fluorescent bulb. 19. There was a missing hand rail end cap outside room [ROOM NUMBER]. 20. In room [ROOM NUMBER], the glass globe on the wall mounted light fixture was cracked and jagged, and there was crumbs, dust and debris inside the vent covers of the wall mounted heater. 21. In room [ROOM NUMBER], the cover was missing from the ceiling mounted heating/cooling unit, the bathroom ceiling exhaust vent cover was coated with dust, and there was a water damaged, bulging ceiling tile in the bathroom. Review of the facility's policy Repair Requisition undated, noted: Purpose: To communicate needed repairs to maintenance and the Administrator by an employee Work orders notify maintenance department of unscheduled maintenance tasks, e.g. fixing a leaky faucet, or changing a light bulb .When a staff member discovers an item that requires repair or maintenance, the staff member shall initiate a Repair Requisition or Work Order . On 3/11/20 at 9:24 AM, the following equipment in the hallway (south unit short hall) was observed blocking entrances to residents' rooms and averting easy access to the exit door: Four wheelchairs One Bedside commode One Hoyer lift One large Geri chair One Sit to Stand Patient Lift One Linen Cart On 3/11/20 at 9:29 AM, an unidentified Certified Nurse Assistant (CNA) was queried about the equipment in the hallway blocking the room entrances. The CNA said, I don't know why it's here. On 3/11/20 at 9:34 AM Nurse Manager K was interviewed and queried about the equipment in the hallway blocking the room entrances. Nurse K said, I'm not sure. I think maintenance are moving it somewhere. The Residential Handbook included: Page 24. Safe environment. You have a right to a safe, clean, comfortable and Homelike environment, including but not limited to receiving treatment and supports for daily living safely.