STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235072	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKVIEW MEDICAL CARE FACILITY	1000 DIANA ST LUDINGTON, MI 49431

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s 7 and 6. Based on interview and record review, the facility failed to provide quality care for two residents (Resident #3 & Resident #4) reviewed for injuries of unknown origin, when the facility failed to timely assess and respond to Resident #3's choking and gagging on fluids, and failed to assess the neurological status in Resident #4 after an unwitnessed fall, resulting in the potential for aspiration pneumonia in Resident #3 and undetected neurological changes in Resident #4. Findings include: Resident #3 (R3) Review of a Face Sheet revealed R3 was an [AGE] year old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. R3 had severe cognitive impairment and required assistance from staff persons for activities of daily living and required extensive assistance from staff to eat or drink. Review of Nursing Progress Note dated 04/05/20 at 6:20 A.M. revealed, R3 Noted to be coughing this am while taking a drink of coffee. Resident able to talk and coughed and cleared throat. Lungs clear. Set up monitoring for difficulty with drinking/swallowing. Review of a Nursing Progress Note dated 04/07/20 at 15:59 revealed, R3 was coughing with fluids, almost gagging at times. Review of a Dietary Progress Note dated 04/08/20 at 08:29 A.M. revealed, Nursing is reporting that resident (R3) is not waking up enough to chew her meals appropriately. Will do a trial of pureed foods for now and continue to monitor. There was no mention of any swallowing concerns for R3 in the dietary progress note. Review of a Nursing Progress Note dated 04/10/20 at 13:59 revealed that R3 continued to cough while taking in thin liquids. Review of a Nursing Progress Note dated 04/12/20 at 13:49 indicated R3 did gag with fluids. Review of a Nursing Progress Note dated 04/13/20 at 08:17 revealed R3 was having some issues with her fluids. Review of a Nursing Progress Note dated 04/13/20 at 15:14 revealed daughter called to see about her mother, was told that we were asking for thickened liquids, r/t (related to) resident (R3) gagging with fluid intake. Review of a Nurse Order Note dated 04/14/20 at 12:16 indicated a verbal order was obtained to trial nectar thickened liquids for R3. Review of a Nursing Progress Note dated 4/15/2020 at 06:25 Has only taken a few sips of thickened water. Review of an Electronic Treatment Administration Record (ETAR) dated April 2020, revealed the following treatment order for R3, Monitor drinking and swallowing for difficulty chewing, coughing on liquids every shift for 3 days. Start 04/05/20 at 0700. Review of the same ETAR revealed that out of 9 shifts of monitoring, one shift (day shift on 04/06/20) indicated that R3 had some difficulty with swallowing. The other 8 shifts had NN (none noted) indicated for the respective shifts. Review of a Nutritional Status Assessment, dated 04/29/20, revealed R3 was being assessed for a significant change in the way she was safely drinking and swallowing. Under the section labeled Swallow Concerns, next to the line coughs/gags while eating/drinking, the assessment indicated that R3 had no concerns with this area. In the same section, under comments was written some dif (difficulty) chewing/dif (difficulty) with fluids in April 2020. Under the section labeled Diet Order the comments listed were 4-24-20 Puree nectar, 4-8 not waking up enough to chew-puree trial, and 4-13 trial nect(nectar thick liquids) rt (related to) gagging on fluids. The document was signed by Registered Dietician (RD) Q. During an interview on 08/20/20 at 8:20 A.M., the Director of Nursing (DON) indicated that the procedure that was followed for any resident with swallowing or drinking concerns was (a) any nurse could downgrade a diet for safety concerns at any time and follow up would occur as soon as possible after the downgrade, (b) if nursing downgraded a diet, they would put in an order for [REDACTED].M., Speech Language Pathology (SLP) P stated that an assessment was completed on R3 in June 2020 when the family requested that R3 be allowed thin liquids to help meet hydration/nutritional needs. SLP P also indicated that an assessment from SLP was not requested for R3 during the month of April 2020. Resident #4 Review of a Face Sheet revealed R4 was a [AGE] year old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Brief Interview for Mental Status (BIMS), dated 07/24/20, revealed R4 was cognitively intact. R4 was able to ambulate independently with a walker and required assistance from staff if fatigued. Review of an Incident summary, dated 04/23/20, revealed R4 reported to staff on 04/23/20 that she had fallen the previous morning (04/22/20) and that R4 was experiencing right wrist pain and was noted to have bruising on the left hip/outer thigh. Further review of the document indicated that R4 was sent to the emergency roiagnom on [DATE] for evaluation and treatment if indicated. Review of Part A Resident/Incident Information & Assessment, dated 04/23/20, indicated .Describe the injury and treatment : left hip hematoma (bruise) 24 cm (centimeters) x 16.5 cm, dark purple in color and right inner thigh bruise 4.5cm x 3.5cm. No monitoring for the bruise located in the right inner thigh could be located in R4's electronic medical record. Review of the electronic health record for R4 did not produce a neurological assessment (neuro checks) for R4 following the fall on 04/22/20. During an interview on 08/19/20 at 9:20 A.M., the Director of Nursing (DON) stated that a review of R4's electronic medical record was done and neuro checks could not be located for the 04/22/20 fall. Review of a facility policy titled Neurological Signs Observation, dated August 10, 2015, revealed the following .The purpose of this observation is to detect clinical manifestations of increased cranial pressure .neurological signs and vital signs are monitored every 15 minutes x 4, then every 30 minutes x 2, followed by every four hours x 5 .(D) Assess changes in level of responsiveness .(E) Observe for restlessness, headache, vomiting, forced breathing, and purposeless movement of body and limbs .(G) Assess grasp of both hands .(H) Assess pupillary change .(J) Use the Neurological Observation Form (OMCF 3-263) for documentation and/or the Electronic Health Record (EHR). Review of a facility Fall Packet Checklist included 8. Neuro observation for falls with head involvement and all unwitnessed falls .4. Orthostatic BP (blood pressure). Review of R4's Blood Pressure Summary, dated April 2020, indicated that orthostatic blood pressures were not assessed on R4 until the morning of 04/27/20.

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