STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235543	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LINCOLN HAVEN NURSING & REHAB COMMUNITY	950 BARLOW RD LINCOLN, MI 48742

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	**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 remove discontinued medications from the resident's medication supply according to pharmacy guidelines for one resident (#8) and failed to utilize the back-up medication supply and correctly enter physician orders [REDACTED].#15) of five residents reviewed for pharmacy services. This deficient practice resulted in the potential for medication errors and diversion of medications. Findings include: An observation of Resident #15's medication administration, on [DATE] at 7:16 a.m., revealed Registered Nurse (RN) E placing two tablets in a medication cup. RN E reported the two tablets were [MEDICATION NAME] (a medication to lower blood pressure and heart rate) 12.5 mg (milligram) tablets. When asked to see the medication card, RN E reported they had used Resident #8's medication. Review of the medication card revealed the following: (Resident #8) [MEDICATION NAME] 12.5 mg tabs. RN E reported Resident #15's medication card had not been received by pharmacy, therefore they borrowed from Resident #8's medication supply. A review of the physician order [REDACTED]. A review of the physician order [REDACTED]. Further review of the order revealed the medication had been discontinued on [DATE]. In an interview with the Director of Nursing (DON), on [DATE] at 12:02 p.m., the DON revealed nursing should never utilize a resident's medication for use on another resident. The DON reported the facility had a back-up supply of medication for use when a resident's medication was unavailable. Review of the back-up medication supply inventory list with the DON at the time of the interview, revealed the back-up supply contained five doses of [MEDICATION NAME] 12.5 mg tablets. Further review of the back-up medication supply with RN F, on [DATE] at 12:08 p.m., revealed no doses of [MEDICATION NAME] 12.5 mg tablets had been removed. RN F reported all five doses remained available for use and were not expired. On [DATE] at 1:50 p.m., the DON reported the process for removal of discontinued medications from the resident's medication supply was for nursing to remove the medication upon receiving the order for discontinuation. The DON reported once the non-controlled medications were removed from the medication cart, they were placed in a bag provided by the pharmacy for return. When asked if Resident #8's [MEDICATION NAME] 12.5 mg tablets should have been removed prior to this Surveyor's observation, the DON reported the medication should have been removed when discontinued on [DATE]. The DON agreed keeping discontinued medications in the medication cart created the potential for diversion of resident's medication. An observation on [DATE] at 3:25 p.m., with RN D, revealed Resident #8's discontinued [MEDICATION NAME] 12.5 mg tablets, had not been removed and remained in the medication cart in the resident's active medication supply. A review of the pharmacy guidelines provided by the Nursing Home Administrator (NHA) and titled, LTC (long-term care) Facility Pharmacy Services and Procedures Manual, revised [DATE], revealed the following, in part: Disposal/Destruction of Expired or Discontinued Medication . Procedure: 2. Once an order to discontinue a medication is received, facility staff should remove this medication from the resident's medication supply. Further observation during Resident #15's medication administration, on [DATE] at 7:06 a.m., revealed RN D approach the DON to ask for clarification of Resident #15's medication administration order recorded on the resident's Medication Administration Record [REDACTED]. A review of Resident #15's MAR indicated [REDACTED]. Twice A Day. Administer 1 tab (5mg) PO (by mouth) BID (twice daily. [DATE] - Open Ended. The DON reported they would call the physician to clarify what dosage the resident should be taking, 2.5 mg twice a day or 5 mg twice a day. The DON returned with a new MAR for the anticoagulant medication that revealed the correct order was 2.5 mg twice a day. During the reconciliation portion of the medication administration survey task, a review of Resident #15's MAR indicated [REDACTED]. Once a Day. A review of the policy, titled, Medication Administration Procedures, dated ,[DATE], revealed the following, in part: B. Dosage: 1. Give the exact number of tablets/capsules ordered. An interview with RN F, on [DATE] at 12:08 p.m., RN F reported the process for receiving medications from the pharmacy was for one nurse to accept the medications and reconcile the medications with the physician's orders [REDACTED]. On [DATE] at 2:59 p.m., the NHA revealed the facility did not have a policy on receiving and entering physician medication orders. The NHA reported the process was for nursing to receive the order for a medication, enter into the resident's electronic health record (EHR), fax the order to the pharmacy, then transcribe the order onto the resident's MAR. On [DATE] at 4:55 p.m., the DON reported the process for entering medication orders was that the nurse receiving the order from the physician would enter the order into the resident's EHR and then transfer the order to the Resident's MAR. When asked how medication orders were received from the physician, the DON reported medication orders were given to nursing verbally or by telephone. The DON reported if a medication order was provided in writing, the written order would be scanned into the resident's EHR after processed by nursing staff. The DON reported if there was not a written order scanned into the EHR, the order would have been given verbally or by telephone. A review of the EHR for Resident #15 revealed no written physician's orders [REDACTED].
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the menus prepared in advance as required, failed to have planned menus for residents on pureed diets, and failed to have the menus reviewed by the facility's dietitian for changes and adequacy. This deficient practice has the potential to result in meals served to residents which fail to meet nutritional parameters and residents frustrated by the practice of not following menus. This has the potential to negatively impact any or all 31 residents. Findings include: On 9/22/20 at 11:39 PM, Resident #26 stated, The food could be better . it does not taste good. On 9/23/20 at 11:31AM, Resident #26 stated, Most of the time you can't tell what it (the food served) is. A review of the Electronic Medical Record (EMR) for Resident #26 revealed the Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status (BIMS) assessment score of 15/15 signifying cognitively intact. On 09/22/20 at 1:04 PM, the lunch meal was observed. Resident #18 stated, I have a rule that if I can't tell what it is, I don't eat it. I am just eating my pudding . Yes, I don't eat mystery meat. Resident #18's plate of green beans and a brown mixture of meat/gravy was untouched. On 09/23/20 at 8:15 AM, the breakfast meal delivery was observed. Resident #18 was eating in his room and he stated, We get this meal quite often. At 9/23/20 at approximately 12:35PM, the lunch meal was observed. Resident #18 was eating only his dessert (lemon pie) while his main plate (meat balls with sauce over noodles and vegetables) remained untouched. Resident #18 stated, I can't eat meat balls they are too tough . I never eat them. A review of the Electronic Medical Record (EMR) for Resident #18 revealed the Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status (BIMS) assessment score of 15/15 signifying cognitively intact. On 09/23/20 at 3:06 PM, a 4-week cycle menu was presented to the survey team electronically by the Nursing Home

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 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Administrator (NHA). The NHA said that the facility had a corporate Registered Dietitian (RD) who reviews menus from (the vendor) and he sends them to the facility. The menus were not signed by an RD, but the NHA said the menus were approved by him as evidence by his emails. The NHA stated that the RD also approves changes to the menu. An email dated 4/9/20 at 12:18PM, was presented by the NHA on 9/25/20 at 10:15 AM and read in part, The email shows I received our menus from my RD. No RD signature or date of review was present on the menus. On 9/23/20 at 2:14PM in an interview, the Dietary Manager (DM) H discussed the menu. It was noted that the written and planned 9/23/20 lunch menu was meatloaf, roasted mashed potatoes, corn, roll and peanut butter brownies. DM H confirmed that instead meatballs with gravy over noodles, mixed vegetables, and lemon pie was served. The question was raised as to why the menu was not followed. DM H answered, I am not sure why we had to change it. I will have to ask (the NHA) . I came in at 7:30 and she (NHA) had already changed it with the Cook (Staff A) this morning. DM H discussed breakfast menu changes on 9/23/20 saying, This morning they had blueberry pancake bake, oatmeal and sausage. The menu says French toast. I don't know why that was changed. On 9/22/20, during the lunch meal it was observed that no salad was served per the planed menu. DM H stated, No, we did not have tossed salad yesterday at lunch. It was not supposed to be on the menu. We had tossed salad at dinner. The menu as sent by the RD showed a planned tossed salad at lunch and dinner for 9/22/20. The observation was made that many changes from the planned menu occurred. When asked where the menu was posted, DM H stated, (NHA) said we do not have to post the menus. On 9/23/20 at 2:20PM, Staff A was interviewed. Menu changes were discussed. Staff A said there was not a separate menu for residents who needed their food pured. Staff A said she would just make appropriate substitutions. Staff A said if the menu said tossed salad she just used a different vegetable instead to pure. They did not pure noodles but used mashed potatoes. Monday we had Texas sheet cake on the menu but we used brownies instead, so we didn't want to have peanut butter brownies at lunch on Wednesday so we substituted the lemon pie. When asked if the menus were saved, Staff A stated they did not save the menus but there was a record of what was served on the temperature log. DM H presented the temperature logs with actual foods served and these were compared to the cycle menu as sent by the RD for the past 10 days from 9/13/20 through 9/23/20. Fifty-four (54) menu items had been changed from the planned menu as emailed by the RD. The dinner meal of 9/22/20 had no record of what had been served as the meal was left blank on the log. This meal could not be included in the comparison. Also, there was no record of the menu items that had been served to the residents on a pureed diet or the substitutions that had been made. Invoices from the vendor from June 2020 to current were received. During the 10 days reviewed the invoices from 9/10/20 and 9/17/20 revealed 5 menu items were out of stock and not delivered. Evidence showing substitutions were reviewed and supported by an RD were requested and were not received by the end of the survey. On 9/25/20 at 10:15 AM, the NHA presented the policy titled: Menu Substitutions Chapter 3.12 and dated as revised 7/16. It read in part, All menu substitutions will be recorded on the substitution list. The date of the substitution, original food item, substitution, and reason will be recorded . Substitutions will be kept on file for six months . Excessive menu substitutions should be reviewed by the Dietitian so that problematic areas can be resolved.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting 31 all residents who receive meal services (oral foods). Findings include: 1. On 09/22/20 at 11:00 AM, the surveyor observed the AM Cook, staff A, placing a sanitizer test strip into a sanitizer wiping cloth bucket for one second and then comparing it to a color chart to determine the solutions concentration. At this time staff A stated, wow, I don't know why this is happening. I guess I'll try it again with a new set, it looks like they got wet. On 09/22/20 at 11:01 AM, the surveyor observed a concentration of zero ppm of quaternary ammonia on the test strip and asked staff A if they could look at the test strips closer to which they stated, yes. On 09/22/20 at 11:03 AM, review of the test strip packaging revealed instructions to, immerse for ten seconds. On 09/22/20 at 11:04 AM, the surveyor observed a policy posted on the wall above the three compartment sink entitled, sanitizing bucket procedure which upon review item number five stated, immersion of test strip for one minute in sanitizing solution should read 200 ppm. On 09/22/20 at 11:06 AM, upon interview with staff A, the surveyor inquired if they received any training on how to test for the sanitizers concentration to which they replied, yes, but we do a lot of on the job training here. At this time the surveyor discussed the instructions on the test strip packaging and procedure posted on the wall above the three compartment sink with staff A to which they stated, lets follow the instructions on the packaging, I think that is something that our distributer posted even though it does say it's our policy. I'm not sure about that, but I know we want it to be at 200. On 09/22/20 at 11:08 AM, staff A tested a new batch of sanitizer solution while immersing the test strip for ten seconds which revealed a concentration of 500 ppm of quaternary ammonia to which they stated, well, that's not right, that's way too much. Let me make another one. On 09/22/20 at 11:10 AM, the additional test by staff A revealed the same concentration of 500 ppm of quaternary ammonia to which they stated, I think I'll pour some out and add straight water to it and see what happens. On 09/22/20 at 11:11 AM, staff A was observed pouring out a portion of the sanitizing solution and adding water into the bucket. At this time staff A retested the solution while immersing the test strip for ten seconds revealing a concentration at 200 ppm to which they stated, finally. I'll talk to the PM cook and let them know we need to do it this way before we can get our supplier out here to work on it. Review of 2013 U.S. Public Health Service Food Code, Chapter 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization Temperature, pH, Concentration, and Hardness directs that: A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling, P 2. On 09/22/20 at 11:18 AM, PM cook, staff B, was observed not washing their hands prior to donning gloves while conducting meal preparation tasks for the days lunch after touching door handles, touching their clothing, touching their cell phone, handling spices, writing on labels, and touching food preparation tables. On 09/22/20 at 12:14 PM, staff B, was observed removing their gloves after handling meal carts, trays and touching the tray line, and without washing their hands donned additional gloves and began placing beverages on meal trays. On 09/22/20 at 12:20 PM, upon interview with the Nursing Home Administrator, staff NHA, the surveyor inquired on what were the hand hygiene expectations for staff when they choose to use gloves as a hand barrier to which they replied, to wash their hands before they put them on. On 09/22/20 at 11:27 AM, staff B, was observed putting away cleaned items such as containers and lids, after handling soiled utensils and sending through the dish machine a load of dishes to be cleaned. On 09/22/20 at 12:17 PM, AM cook, staff A, was observed handling clean serving utensils after placing soiled equipment in the dish machine and pulling down on the lever to activate the machine. At this time the surveyor requested a hand hygiene policy from staff NHA to which they replied, of course. On 09/22/20 at 11:39 AM, and at 12:32 PM, staff B, was observed not using a hand barrier to shut off the faucet after washing their hands. On 09/23/20 at 9:39 AM, record review of a policy entitled, hand washing/ hand hygiene revealed in the policy section under item number two that staff are required to wash hands, after removing gloves or other personal protective equipment. Additionally, in the procedure section under item number six the policy states regarding staff hand washing techniques to, turn off the faucet using a paper towel. Review of the U.S. Public Health Service 2013 Food Code, Chapter 2-301.14 When to Wash directs that: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLEUSE ARTICLES and: and contamination and to prevent cross contamination when changing tasks; (E) After handling soiled EQUIPMENT or UTENSILS; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate hospice services for one Resident (#12) of one

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F 0849 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) resident reviewed for hospice services. This deficient practice resulted in the potential for hospice care not being provided and lack of continuity of care between the hospice and the facility. Findings include: A review of the Electronic Medical Record (EMR) for Resident #12 revealed on 6/24/19 skilled hospice services were started. The Minimum Data Set (MDS) assessment dated [DATE], indicated hospice care was currently being received by Resident #12. The EMR revealed only six entries for Resident #12's hospice visits since 1/1/20. On 9/23/20 at 3:56 PM, the Director of Nursing (DON) stated, I only see six notes uploaded into the system in the resident's document section in the chart (for 2020). The DON reported that the hospice staff met with the nurse but did not leave notes, and the facility did not get a copy of the hospice notes. The DON stated, They (hospice staff) used to print their notes once a month, but they are not doing that anymore. The DON stated, I do have a log in (to the Hospice system) but have not been able to see the notes. On 9/23/20 at 4:06 PM, an interview with Registered Nurse (RN) F, revealed Resident #12 was currently listed as receiving hospice care. RN F reported hospice nurses would touch base with the facility nurse after their visit but said they did not leave any documentation. RN F stated, There was a sign in sheet they used to use. She located a binder for hospice and palliative care which revealed one sheet for Resident #12. This sheet had six signatures since 12/26/19. There were three visits signed by a hospice nurse in December 2019, two visits by a hospice nurse in January 2020, no visits recorded in February 2020, and only one visit recorded by a hospice Certified Nurse Aide (CNA) on 3/4/20. No other visits were recorded. The DON stated there was a time that hospice nurses were not coming into the building due to Covid-19, however they (hospice) have started coming in again. RN F found the Hospice Inter-disciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report from 7/15/20 for Resident #12. This report indicated the previous IDG meeting was conducted two weeks prior and was a recurring meeting. Several IDG comprehensive assessments from prior dates were noted, but no current hospice plan of care update report could be found. The 7/15/20 plan of care indicated the following plan: skilled nurse (SN) visits every week, RN visits every two weeks, and hospice health aide visits twice per week. These visits could not be verified to have occurred. On 9/23/20 at 11:21 AM, the hospice contract in place, dated 9/28/17, was reviewed. It read in part: Hospice will develop . A plan of care for the management and palliation of the resident's terminal illness . The plan of care will identify the care and services that are needed and will specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care . The plan of care will be updated as often as the patient condition requires, but no less frequently than every 15 calendar days. A copy of each updated plan of care will be furnished to the facility upon each update, but no less frequently than every 15 days.