| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235446 | A. Building<br>B. Wing | 03/20/2024 |

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| Autumnwood of Deckerville | 3387 Ella St<br>Deckerville, MI 48427 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771<br><br>This Citation pertains to Intake Number MI00138266.<br><br>Based on observation, interview and record review, the facility failed to ensure the provision of residents' rights and dignified living conditions for three residents (Resident #11, Resident #12, and Resident #39), out of a sample of 18 residents, resulting in Resident #11 and Resident #12 having strong offensive odors in their room and bathroom and potential lack of availability of the phone for Resident #39 and feelings of embarrassment, shame, frustration, isolation, and loneliness.<br><br>Findings include:<br><br>Resident #11:<br><br>A Review of Resident #11's medical record revealed an admission into the facility on [DATE] with re-admission on 5/14/18 with diagnoses that included Alzheimer's disease, dementia, psychotic disorder, mood disorder, depression, anxiety and glaucoma. A review of the Minimum Data Set (MDS) assessment revealed the resident had severely impaired cognitive skills for daily decision making and needed moderate assistance with activities of daily living for toileting hygiene, bathing self and dressing.<br><br>On 3/18/24 at 10:38 AM, an observation was made of Resident #11 lying in bed sleeping. A strong odor of urine was smelled outside the Resident's room in the hallway. A Resident was seated in the hallway sleeping in their wheelchair. Upon entering Resident #11's room, a strong odor of urine was smelled in the bathroom. The bathroom was clean except for the strong urine smell. The floor was sticky in the room near the Resident's bed.<br><br>On 3/18/24 at 2:09 PM, an observation was made of Resident #11 sitting in a wheelchair propelling herself in the room. The Resident was asked questions but did not answer questions appropriately or engage in conversation. The Resident was clean. The room smelled of urine and the bathroom had a very strong smell of urine. The floor in the room was very sticky.<br><br>Resident #12:<br><br>(continued on next page) |

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.

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #12's medical record revealed an admission into the facility on [DATE] and readmission on 5/12/23 with diagnoses that included paranoid schizophrenia, dementia, weakness, heart disease and retention of urine. A review of the MDS assessment revealed the Resident had moderately impaired cognition and needed partial/moderate assistance with toileting hygiene and personal hygiene and supervision or touching assistance with toilet transfer.<br><br>On 3/18/24 at 10:11 AM, during the initial tour of the facility, an odor was noted in the 100 hallway. An observation was made of Resident #12 lying in bed sleeping. The Resident did not arouse at that time. A fan was blowing in the room, directed at the bathroom. There was a strong smell of urine and cleaning liquid in the bathroom and the Resident's room.<br><br>On 3/18/24 at 12:52 PM, an observation was made of Resident #12 not in his room. The bed is unmade and the pad on bed has a bowel movement smear on it. The room smells of urine and the bathroom had a strong smell of urine. The fan was blowing and directed towards the bathroom.<br><br>On 3/18/24 at 1:13 PM, an observation was made of Resident #12 dressed and in his room. There was an odor of urine that was noted in the hall outside Resident #12's room. The odor was strong in the room and very strong in the bathroom. The Resident was interviewed, answered questions and engaged in conversation. When asked about showering, the Resident reported that he did not get a shower yesterday (Sunday) and stated, I was supposed to have one, but no one came to get me. He indicated he wanted a shower.<br><br>On 3/19/24 at 2:10 PM, an observation was made of Resident #12 sitting in his chair in the room. An odor was noted in the hall outside of Resident #12's room, the room had an odor, and the bathroom had an odor.<br><br>On 3/19/24 at 2:25 PM, an observation was made of housekeeping cleaning Resident #12's room. The Housekeeping Aide K was interviewed regarding cleaning schedules. The Housekeeping Aide indicated the rooms were cleaned once a day every day. When asked about the odor in Resident #12's room, the Housekeeping Aide indicated an ongoing issue with the odor and stated, It smells every day, and reported they try to put something in the water to freshen it up or open a window if nice outside and the Resident was not in the room.<br><br>On 3/19/24 at 2:55 PM, an interview was conducted with Nurse L and Unit Manager, Nurse N regarding Resident #12's shower that was missed on Sunday. The Nurse reviewed the Resident's medical record and indicated the Resident was documented as getting a shower on Sunday and indicated they would offer one to the Resident today. When asked about the odor in Resident #11 and 12's room, Nurse L indicated housekeeping cleans the rooms daily and deep cleaning was done but the odor was an ongoing issue.<br><br>Resident #39:<br><br>A review of Resident #39's medical record revealed an admission into the facility on [DATE] with diagnoses that included heart failure, dementia, adjustment disorder with mixed anxiety and depressed mood, and schizoaffective disorder, bipolar type. A review of the MDS, dated [DATE], revealed the Resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15/15. The Resident had a Guardian that was the responsible party.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/18/24 at 11:13 AM, an observation was made of Resident #39 dressed and sitting in her wheelchair. The Resident answered questions and engaged in conversation. The Resident was asked about issues she had with her care at the facility. The Resident reported she was not allowed to have her phone except on the weekends. The Resident explained that she would call her friend of [AGE] years and stated, I try to keep the relationship going but I can't, and reported she liked to call her brother and sister-in-law. The Resident reported the staff keep her phone at the nurses' station, she was supposed to be given the phone on Saturday and Sunday and stated, I am supposed to have it all day, but they forget, and I don't get it until late in the day, then they take it away again. The Resident expressed feelings of aggravation and stated, I feel trapped here. An observation was made of no phone on the Resident's table, dressers or bed.<br><br>A review of Resident #39's care plan revealed a focus (Residents name) has an actual behavior problem R/T (related to): Schizophrenia. She becomes obsessive with calling local agencies, 911, authorities, etc. due to delusional thought process and paranoia. Guardian requests she only have her cell phone on the weekends to call her family members . Interventions included Maintain (Resident's name) cell phone at the nursing station. Provide it to her on the weekend only to call her family per Guardian's wishes r/t past successful plan of care, date initiated 1/16/23.<br><br>On 3/19/24 at 2:56 PM, an interview was conducted with Nurse L and Unit Manager N regarding Resident #39's concern with lack of phone given to her on the weekends. Nurse L indicated that when she was on the weekend, the phone was given to Resident #39 in the morning with medications. The Nurse and Unit Manager were asked if the Resident had ever called 911 and they indicated they had not had any issues with her calling 911. When asked if the Resident had been given a trial of phone use during the week while at this facility, it was indicated a trial was conducted. The Nurse indicated the Resident had come to this facility with the intervention of getting the phone only on the weekend due to excessive calling of agencies and others. The Unit Manager and Nurse indicated that the Resident had adverse behaviors related to phone use and limiting phone use was helping with the behaviors and mood. When asked about documentation that the Resident actually received the phone on the weekends, the Nurse indicated they do not document when the Resident got the phone. The Unit Manager reviewed the medical record, indicated a lack of documentation of behaviors leading to restricted phone use and when the Resident received the phone on the weekends. The Unit Manager reported she would put it in so there was documentation that the Resident would get her phone on the weekends at specific times.<br><br>On 3/20/24 at 1:38 PM, an interview was conducted with the Director of Nursing (DON) and Administrator (NHA) regarding Resident #39's restricted phone use. It was reviewed with the DON and NHA of the lack of behaviors documented at the facility for the intervention of restricted phone use, but it was reported the intervention was working for the Resident and the Resident was following the intervention. The lack of documentation of when the Resident received the phone and the Resident's complaint of not receiving the phone as scheduled on the weekends was reviewed with the DON and NHA. A concern with Resident #11 and 12's room odors had been reviewed. The NHA had indicated that the cleaning schedule would be changed to include those rooms to be cleaned by housekeeping twice daily instead of the once daily that was scheduled.<br><br>A review of facility policy titled, Guest/Resident Rights, effective 5/1/22, revealed, Policy: The facility protects and promotes the rights of each guest/resident. The guest/resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666<br><br>This Citation Pertains to Intake Number MI00137710.<br><br>This Citation has two Deficient Practice Statements (DPS).<br><br>DPS #1:<br><br>Based on observation, interview and record review, the facility failed to ensure that appropriate interventions were in place to secure a resident in a van during a transport to prevent a fall with serious injury for one resident (Resident #8) of 5 residents reviewed for falls and accidents, resulting in Resident #8 falling out of a wheelchair in a facility van and sustaining two right leg fractures.<br><br>Findings Include:<br><br>Resident #8:<br><br>Accidents<br><br>A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #8 revealed the resident was admitted to the facility on [DATE] with diagnoses: history of a brain tumor, morbid obesity, heart disease, fibromyalgia, depression, chronic pain, and neuropathy. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 14/15 and the resident needed some assistance with all care; and could feed self and perform oral care with set up assistance.<br><br>On 3/18/24 at 11:05 AM, during a tour of the facility, Resident #8 was observed awake, lying in bed. The resident stated, I broke my right leg in two places when I was riding in the van going to my doctor's appointment. The resident said a facility Staff member T was driving the van. Resident #8 stated, He forgot to put my seat belt on. My leg is still sore, but it is mostly healed. I'm not walking on it; I broke it in 2 places. The resident said she also had prior falls at the facility. She said she has pain, but pain medicine helps.<br><br>A review of the Incident and Accident report dated 11/1/2023 and facility investigation revealed Resident #8 was riding in a facility van with Driver T. The driver stepped quickly on the van brakes to avoid a collision, as another car pulled out in front of him and the resident flew forward out of her wheelchair. The resident was tangled between the two front seats. The van driver could not move the resident and drove her to the ER.<br><br>The facility investigation determined the driver secured the wheelchair to the van floor, but he did not use the seat belt appropriately to secure the resident while she was sitting in the wheelchair. He placed the seat belt straps under the armrests on the wheelchair instead of appropriately around the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the progress notes revealed the following:<br><br>11/1/2023 3:43 PM a nurses note, Per transportation driver, while on the way to an appointment . they were cut off by another vehicle on the road. Driver hit the brakes in an effort to avoid collision with the other vehicle . However, when he hit the brakes (Resident #8) slid forward out of her wheelchair, with her legs extended out in front of her between the front seats of the van .<br><br>11/1/2023 7:53 PM a nurses note, Resident LOA (leave of absence) 0615 am to (doctor) appointment. Returned 1707 (5:07 PM from hospital) . Resident has (diagnosis) Closed fracture Distal end of right Fibula and Tibia. Soft cast in place. Ice applied for comfort to right leg .<br><br>11/1/2023 10:46 PM a nurses note, . reported pain 9/10 in bilateral legs .<br><br>11/2/2023 at 12:16 PM a resident at risk note, Resident is being reviewed by IDT (interdisciplinary team) related to incident that occurred on 11/1/2023 at 0715 (am) . Intervention implemented: Staff education related to resident positioning and safety devices in the transportation van .<br><br>11/3/2023 at 9:50 PM a nurses note, . rates pain at 10 prior to scheduled Tylenol and Norco .<br><br>11/14/2023 at 11:26 PM a nurses note, Resident continues to be on scheduled pain medications that has been limited effective per resident .<br><br>11/17/2023 at 11:44 PM a nurses note, . residents tibia/fibula x-ray, .Acute distal tibial shaft fracture. Acute distal fibular shaft fracture. Moderate soft tissue swelling seen on the ankle .<br><br>On 3/19/2024 at 1:00 PM, the facility provided a packet of past non-compliance related to the fall with fracture incident that occurred during van transport for Resident #8. The facility said the incident occurred on 11/1/2023 and they said they provided staff education and attained compliance on 11/10/2023. The packet incident and investigation were further reviewed. This surveyor requested to review the education provided to the staff and to review competencies for Van driver T completed prior to the incident.<br><br>On 3/19/24 at 4:29 PM the Director of Nursing/ DON was interviewed related to education provided to the Van drivers/ Transporters: CNA/Driver U and CNA/ Q. Driver T did not have education related to proper use of the van seatbelt for residents prior to the incident.<br><br>On 3/20/2024 at 11:00 AM reviewed the education file for Van Driver T. He did not have education related to proper use of the seatbelt in the van to secure a resident in a wheelchair.<br><br>A review of the facility provided document titled, Q'straint: Use and Crae Manual-QRT-360 4-Point Wheelchair Securement System, dated 2014 revealed, . Compliant shoulder and pelvic belt restraint must go across occupant's shoulder and pelvic (lap), and not be worn twisted or held away from the occupant's body by wheelchair components<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the facility policy titled, Transportation of a Resident in Facility Van, dated 12/30/2022 and revised 2/9/2023 provided, Residents will be safely transported via the facility transport van. The transport driver will meet the requirements of the job description for transport van driver. Processes are in place to promote the safety of residents and employees during transport in company vehicles and to minimize resident/employee injury . Keep all seat belts, safety restraints, and wheelchairs secure following the manufacturer's instructions . The driver will have documented wheelchair transportation safety training . The wheelchair is secured following manufacturer's guidelines and facility procedure upon entering the vehicle . Vehicle driver training: 1. An employee may not attempt to transport a wheelchair user in the van without having been instructed on proper operation of wheelchair securement and occupant restraint systems. 2. All vehicle drivers are trained using education materials before transporting resident in the van. 3. Training includes viewing the Q'straint QRT system video (or system specific to the van used), a demonstration of the use of the wheelchair lift and restraint system, completion of the competency checklist and return demonstration. 4. The competency will be completed initially and annually.<br><br>DPS #2:<br><br>Based on observation, interview and record review, the facility failed to ensure appropriate interventions were in place and supervision was provided to prevent a fall with injury for one resident (Resident #22) of 5 residents reviewed for falls/accidents, resulting in Resident #22 falling out of a chair, hitting her head and suffering an epidural hematoma.<br><br>Findings Include:<br><br>Resident #22:<br><br>Accidents<br><br>A record review of the Face sheet and MDS assessment indicated Resident #22 was admitted to the facility on [DATE] with diagnoses: history of a stroke, heart disease, depression, history of delusions, and obesity. The MDS assessment dated [DATE] indicated the resident had moderate cognitive loss with a BIMS score of 10/15 and the resident needed assistance with all care.<br><br>On 3/18/2024 12:32 PM during a tour of the facility, Resident #22 was observed leaving the main dining room. She was slowly wheeling her wheelchair. Her right eye and forehead were covered in purple, yellow bruises.<br><br>On 3/19/2024 at 10:15 AM, Resident #22 was observed in her room, sitting in her bedside chair. She said she fell at the facility when she was walking on her own. A lift sling was observed underneath the resident. She said she previously had a stroke and had right sided weakness. Her right hand had a splint on it, It just won't do what I want.<br><br>A record review of the Incident and Accident reports for Resident #22 revealed she had fallen previously on 10/9/23, 1/9/24 and 3/8/2024:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 10/9/2024 at 6:50 PM- Resident in room . Resident room [ROOM NUMBER] A in hallway going to his room and told CENA (certified nursing assistant), Someone is yelling. CENA approached room and observed Resident (#22) sitting on floor at end of her bed. Resident stated, I stood up from my wheelchair and sat down. I was trying to walk to bathroom. Resident did not use call light . Impairment of memory wait for assistance .<br><br>1/9/2024 at 6:55 PM- Resident was lying on her back with her knees bent in the middle of her room next to her wheelchair. Resident has skin tear to the top of her right hand . and she has a hematoma to the right side of her forehead . I was trying to clean up my blankets and stuff by the wall and fell out of my chair and hit my head on the floor, I rolled over and tried getting myself up but couldn't . care plan updated to encourage resident to ask for assistance . Predisposing Physiological Factors: confused . impaired memory .weakness . gait imbalance .<br><br>3/8/2024 at 4:40 PM- At 1640 (4:40 PM) resident was observed on the floor curled in a slight fetal position on her right side with her feet facing the bathroom door, head & body between the register & bed with top of head facing the register & the right side of her face lying on the floor. Moderate amount of blood noted at head level. Her glasses were beneath her right temporal lobe, one lens was out . There was an immediate golf ball sized nodule with bruising on the right upper forehead. There was a 1.5 cm & a 2 cm linear laceration above the right eye . She stated she was attempting to stand to walk into the bathroom & went down on her right side . order obtained to transfer to (hospital) for evaluation . 1735 (5:35 PM) ambulance arrived for transfer . impaired memory, gait imbalance. Incontinent . orthostatic bp's (blood pressures) were added to the care plan x 3 days .<br><br>A review of the summary report of the incident for Resident #22 on 3/8/2024: . Report received from nurse at (hospital) stating that resident had a small brain bleed and fracture to the right skull . sent to (another hospital) where CT scan was repeated on 3/9/2024 . hyper dense right frontal scalp hematoma . no skull fracture .<br><br>A review of the progress notes for Resident #22 identified the following:<br><br>2/22/2024 at 3:55 PM a nurses note, This writer was walking past the Internet cafe and observed the resident sitting in a regular chair next to the table in front of the fish tank, attempting to stand to transfer back into her w/c (wheelchair) . Resident educated on the importance of asking staff for help to move from one chair to another and she replied, Ok, but I can do it myself, I just did.<br><br>2/26/2024 at 4:40 PM: This nurse walking past resident entrance door. Noticed resident in her recliner reaching for her wheelchair. Nurse asked, . Do you need help: Resident stated, Yes. I want to get in this wheelchair and go eat. Nurse stayed with resident until mechanical lift available .<br><br>3/4/2024 at 12:45 PM: Resident observed . Motioning to self-transfer from her wheelchair to her recliner in her room . CENA's x 2 mechanical lift transfer done from wheelchair to her recliner.<br><br>3/8/2024 at 8:26 PM: At 1640 resident was observed on the floor curled in a slight fetal position on her right side . Moderate amount of blood noted at head level . There was an immediate golf ball sized nodule with bruising on the right upper forehead. There was a 1.5 cm and a 2 mm linear line laceration above the right eye . Lying blood pressure was obtained 181/138 & upon being assisted to sitting position on floor she c/o (complained of) dizziness with position change, sitting BP was 181/85. Unable to stand for standing BP .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the Care Plans for Resident #22 identified the following:<br><br>(Resident #22) has the potential for impaired communication related to word finding difficulty at times secondary to CVA (stroke), date initiated 6/2/2023 and revised 9/6/2023 with intervention Anticipate and meet needs as needed, date created and initiated 12/31/2020.<br><br>(Resident #22) has incontinence of bowel and bladder and is at risk for UTI's and skin breakdown related to cognitive impairment, decreased mobility, date created 1/12/2021 and revised 12/7/2022 with intervention Check resident q 2 hours and prn (as needed) for incontinence . date initiated and revised 1/12/2021.<br><br>(Resident #22) is at risk for fall related injury and falls related to CVA with right sided deficits, weakness, poor safety awareness, hallucinations and delusions, believes that she is able to self transfer and ambulate independently, date created 12/31/2020 and revised 3/13/2024 with intervention: Tilt wheelchair seat back, 6/29/2022; Refer to psych services related to hallucinations and delusions that may have contributed to fall on 3/8/2024, created and initiated 3/8/2024 and revised 3/13/2024.; Put the residents call light within reach and encourage him/her to use it for assistance as needed, initiated 12/31/2020 and revised 3/13/2024; Note put outside of Resident Bathroom Door Remember to ask for assistance when using bathroom, date initiated 10/9/2023; Increase CENA rounding/offers to go to restroom, date initiated 3/18/2022 and revised 12/16/2022.<br><br>Resident #22 had repeated attempts to transfer herself from chair to chair, bed to chair or chair to bathroom. The staff documented the resident had poor memory and cognitive decline, but interventions were to remind her to use her call light and a note to ask for assistance. An intervention mentioned increased nurse aide rounding, but it didn't specify how often. The resident's blood pressure was very high (181/138) after falling on 3/8/2024 and then lower (181/85) upon sitting and an intervention on the incident report said to monitor for 3 days; this was when the resident was hospitalized for the head injury. Monitoring did not resume when the resident returned to the facility. The resident's falls were all before or after a meal. This was not addressed by the facility.<br><br>Resident #22 was observed attempting to stand and transfer self on several occasions prior to the fall with head injury on 3/8/2024 that required hospitalization : 2/22/2024, 2/26/2024, 3/4/2024. There were no additional interventions to aid in preventing the resident's continued falls with injury.<br><br>On 3/19/24 at 2:00 PM, the DON was interviewed related to Resident #22's recurrent falls. Reviewed the nursing documentation that the resident was repeatedly attempting to stand and transfer self, but interventions were not specific to address the resident's risk for falls. She said the facility was working on falls.<br><br>A review of the facility policy titled, Fall Management, origination date 5/1/2010 and revised date 9/22/2023 provided, The facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls. Each resident is assisted in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate . A plan of care is developed and implemented . |

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| Autumnwood of Deckerville | 3387 Ella St<br>Deckerville, MI 48427 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771<br><br>Based on observation, interview and record review, the facility failed to ensure monitoring of blood glucose levels for one resident (Resident #46), who was admitted back to the facility with a tube feeding of enteral nutrition, and who did not receive the ordered enteral nutrition formulated for a diagnosis of diabetes of one resident reviewed for tube feeding, resulting in blood glucose levels not being monitored and the potential for elevated blood glucose levels to be left untreated which could adversely impact health and well-being.<br><br>Findings include:<br><br>Resident #46:<br><br>On 3/18/24 at 1:48 PM, an observation was made of Resident #46 lying in bed, awake. The Resident was asked questions, but the Resident did not respond with answers and did not engage in conversation. An observation was made of enteral nutrition hanging on a pole with tubing that was in a controller, turned off and not infusing at this time. The enteral nutrition was labeled as Glucerna and had the Resident's name and date on it.<br><br>A review of Resident #46's medical record revealed an admission into the facility on [DATE] and readmission on 1/4/24 with diagnoses that included dementia, metabolic encephalopathy, pressure ulcer of right heel, and diabetes. The Resident had a PEG tube/G-Tube (percutaneous endoscopic gastrostomy tube-a tube placed in the stomach to administer nutrition) and received enteral nutrition. A review of the Minimum Data Set assessment dated [DATE], revealed the Resident had severely impaired cognitive skills for daily decision making and was dependent of care of activities of daily living.<br><br>A review of Resident #46's orders revealed an order for Enteral Feed Order one time a day Glucerna 1.5 at 50 ml/hr (milliliters per hour) continuously via PEG tube until 1200 ml infused to provide 1800 Kcal . with a start date on 1/5/24 and hold date 1/4/24 to 1/9/24. Another order for enteral feed, one time a day until Glucerna 1.5 arrives from supplier, provide Jevity 1.5 PEG tube at 50 ml/hr (milliliters per hour) continuously until 1200 ml infused to provide 1800 kcal . with a start date on 1/5/24. A review of the Medication Administration Record (MAR) the Jevity was started on 1/5/24 and continued through 1/10/24. The Glucerna was started on 1/10/24. An order for glucose monitoring revealed an order for Accu Check one time a day every Tues, Thu, Sat for DM (diabetes mellitus) with a start date on 2/15/24 and then changed to one time a day every 7 days with a start date on 3/7/24.<br><br>A review of Resident #46's Nursing Comprehensive Evaluation dated 1/4/24, revealed, Summary: admitted at 1335 from (hospital name) via EMS. Res was admitted on to (hospice name) services while at the hospital Dx (diagnosis) of Dementia. Res (resident) niece who is his guardian wishes res to be a full code and is discussing with other family, with intentions of changing to a DNR (do not resuscitate). Res is currently NPO (nothing by mouth) and has peg tube, newly placed end of December. Tolerating feeding well .<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #46's laboratory results revealed and HBA1C (hemoglobin A1C) dated 12/3/23 of 8.6 (high) with a reference range of 4.8-6.0. A review of the hospital Laboratory Discharge Summary Report, revealed blood glucose results for 1/3/24 at 12:49 AM 254 (high); 5:49 AM 236 (high), 12:00 PM 264 (high); 6:10 PM 260 (high); 1/4/24 at 12:34 AM 201 (high) and 5:37 AM 239 (high). Review of the hospital medication record revealed the Resident was administered insulin twice a day and insulin by sliding scale prior to admission into the facility. A review of the hospital record of the dietitian consult dated 1/2/24 revealed the Resident was to have Glucerna 1.5 at 50 ml/hr enteral feeding.<br><br>A review of Resident #46's medical record revealed a lack of documentation for assessment and monitoring for hyperglycemia and/or blood glucose monitoring while on the enteral nutrition Jevity until the Glucerna was available.<br><br>On 3/19/24 at 12:48 PM, an interview was conducted with Dietary Manager/Social Services (DM) A regarding the difference between Glucerna and Jevity. The DM indicated that Glucerna was geared towards a Resident that was diabetic and needed enteral nutrition and that Jevity was not typically used for diabetic tube feeding. When asked about availability of the Glucerna, the DM stated, If we don't have it in stock, we give something we do have on hand until it becomes available, we utilize what's on hand. When asked about monitoring the blood glucose when using a tube feeding solution that was not geared for a Resident with diabetes, the DM indicated that they should be keeping a close eye on blood sugars. When questioned about the dieticians' recommendations, a review of Resident #46's medical record revealed the dietician seen the Resident when the tube feeding Glucerna had come in and the Jevity had been discontinued. There was a lack of documentation that the dietician had been contacted regarding monitoring of the blood glucose.<br><br>On 3/20/24 at 11:43 AM, an interview was conducted with the Unit Manager V regarding Resident #46 enteral nutrition when admitted back to the facility on [DATE]. The Unit Manager reported the Resident had been unresponsive, transferred to the hospital, was intubated and then had the tube feeding placed. Review of medical record with the Unit Manager revealed the Resident received the Jevity until the Glucerna came in and the blood glucose levels were not monitored. The Unit Manager indicated the lack of blood glucose monitoring was a hospice order for comfort. When asked to assist in finding the order or that the blood glucose monitoring was addressed while on the Jevity when the Glucerna was not available, the Unit Manager was unable to find documentation in the Resident's medical record. When asked why the blood sugars had been monitored in February, the Unit Manager indicated that there was a time period for monitoring of the blood sugars because the dietician wanted them. The Unit Manager reviewed Resident #46's medical record and reported she did not see documentation that addressed on admission or while on the Jevity to monitor or not monitor the Resident's blood glucose levels and revealed the Resident was monitored in the hospital with high blood sugar levels and was on the Glucerna.<br><br>A review of facility policy titled, Diabetic Management, effective 9/22/23, revealed, Diabetic Management involves both preventative measures and treatment of complications. Upon admission, the interdisciplinary team works together to implement a plan of care to minimize complications. Evaluation: Upon admission the interdisciplinary team evaluates the diabetic resident and implements a plan of care to ensure: Orders are received and are accurate related to blood glucose monitoring and anti-diabetic agents. Blood glucose orders should include parameters to follow and when to notify the physician. Appropriate nutritional orders are in place . |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666<br><br>Based on observation, interview and record review the facility failed to maintain respiratory equipment in a sanitary manner for one resident (Resident #35) of one resident reviewed for respiratory care, resulting in the potential for exposure to infectious organisms and respiratory decline.<br><br>Findings Include:<br><br>Resident #35:<br><br>Respiratory Care<br><br>A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #35 indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Diabetes, chronic kidney disease, end stage renal disease, heart failure, gout, respiratory failure, COPD, morbid obesity, and chronic pain. The MDS assessment dated , 1/23/2024 indicated Resident #35 had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15 and the resident needed assistance with care.<br><br>On 3/18/24 at 10:41 AM, during a tour of the facility, Resident #35 was observed to be out of her room. Next to the bed was an oxygen concentrator with oxygen tubing in a clear bag that was sitting on the floor. A CPAP (Continuous positive airway pressure) machine was sitting on a bedside stand. The glass water container attached to the machine had cloudy water inside and the container was dated change 9/5/23.<br><br>On 3/18/24 at 12:42 PM, Certified Nursing Assistant/CNA Q was in the room with Resident #35. She said the resident had just returned from dialysis. CNA Q was asked about the water container on the CPAP machine dated 9/5/23 and the CNA said she didn't know why it was dated 9/5/23 or what it meant. Resident #35 said the staff filled the glass water container on the CPAP machine. When asked where they obtained the water from, the resident pointed to the closet. Inside the closet was a distilled water jug dated 2/23/24, sitting on the floor of the closet. The resident said the nurses or aides filled the CPAP water container. She said they were supposed to clean the CPAP every day, But I don't know if they do. I'm gone to dialysis three days a week.<br><br>On 3/20/24 at 2:53 PM, Infection Prevention/IP Nurses R and S were interviewed in Resident #35's room. They were asked about the water container on the CPAP machine that was still dated 9/5/23. The nurses were asked to look at the water in the container; it was still cloudy. The IP nurses did not know why the water container was dated change 9/5/23 or why the water was cloudy. They did not know about a cleaning schedule for the machine.<br><br>A review of the facility policy titled, Oxygen administration, long-term care: Lippincott procedures, undated and printed by the facility on 3/20/2024, revealed, . It is recommended open distilled water container be changed weekly .<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | National Council on Aging (NCOA), Dated Sep 08, 2023, How to Clean a CPAP Machine, provided Regularly cleaning your CPAP machine boosts its life span and protect you from certain types of infections . Consult your manufacturer's guide for cleaning tips specific to your CPAP device components . A dirty CPAP machine can make you sick. Keeping it clean reduces your risk of rashes and allergies, along with bacterial, fungal, and respiratory infections . You'll want to replace the water in your humidifier's water chamber daily to prevent bacterial growth. Plan on a weekly deep clean . The Centers for Disease Control and Prevention recommends distilled water in medical devices to reduce your exposure to waterborne pathogens. This makes distilled water ideal for both CPAP humidifier usage and cleaning . |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471<br><br>Based on observation, interview, and record review the facility failed complete timely assessments after the installment of enabler bar, continue monitoring for the appropriateness of bedrails, and obtain consent prior to use for two residents (Resident #21 and Resident #43) of two residents reviewed for bed mobility resulting in the potential for entrapment and a decline in mobility.<br><br>Findings Include:<br><br>Resident #21:<br><br>During initial tour on 3/18/2024, Resident #21 was observed watching television and enjoying her lunch. She was not able to hold a conversation due to her disease process but did appear to be in good spirits. Observed on her bed was a right sided enabler bar.<br><br>On 3/18/2024 at approximately 11:45 AM, a review was completed of Resident #21's medical records and it indicated the resident was admitted to the facility on [DATE] with diagnoses that included Dementia, Anxiety, Major Depressive Disorder, Anemia, Alzheimer's, and bipolar disorder. Further review yielded the following:<br><br>Physician Orders:<br><br>-Turn assist bar to right side of bed as enabler device to aide with bed mobility and transfers. Ordered on 9/24/2021.<br><br>Care Plan:<br><br>.Turn assist bars applied to bed to assist with bed mobility and safe transfers following incident 6/5/2021 .<br><br>After review of Resident #21's record there was no documentation located regarding the ongoing monitoring and assessment of need of enabler bar, risk versus benefits and informed consent.<br><br>Resident #43:<br><br>During initial tour on 3/18/2024, Resident #43 and his roommate were observed enjoying their lunch and chatting with one another. Resident #43 had a left sided enabler bar affixed to his bed.<br><br>On 3/18/2024 at approximately 12:00 PM, a review was of Resident #43's medical records and it indicated he was admitted to the facility on [DATE] with diagnoses that included, Dementia, Diabetes, Major Depressive Disorder and Chronic Obstructive Pulmonary Disease. Further review revealed:<br><br>Physician Orders:<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Turn left assist bar to bed. Ordered on 9/5/2023.<br><br>Physical Device Evaluation:<br><br>-Evaluation was completed two months after left enabler bar was installed.<br><br>After review of Resident #43's record there was no documentation located regarding the initial assessed reason, risks versus benefits and informed consent for the left sided enabler bar.<br><br>On 3/19/2024 at 3:57 PM, Maintenance Director C was asked the process for installing enabler bars on resident beds. He reported his department will receive an order from therapy to install the enabler bar (right, left, or bilateral). Monthly, thereafter they complete checks for functionality, tightness, wear/tare. Director C showed this writer their monthly enabler bar safety checks that were completed for all facility residents.<br><br>On 3/19/2024 at 4:30 PM, the Administrator and DON (Director of Nursing) were interviewed regarding the process for enabler bar installment. They reported the initial assessment is completed by therapy department and if the resident is deemed appropriate, they will place a maintenance request for installation. They were asked where to locate ongoing monitoring and it was explained there would not be any ongoing nursing monitoring once the enabler bars were installed. Consents for enabler bars for Residents #21 and #43 were requested in addition to the bedrail policy.<br><br>On 03/20/24 at 10:50 AM, the Administrator explained upon an enabler bar being installed, nursing staff will complete their Physical Device Evaluation (PDE). Since the enabler bar did not meet the criteria to be classified as a restraint they would not move forward with any other processes related to assessment/monitoring or consents. The Administrator stated she was unable to locate a consent or any documentation that notification to guardian/responsible party of the implementation of the enabler bars for Residents #21 and #43 was completed. A discussion was held with Administrator regarding the need for ongoing assessment and monitoring of the enabler bars to ensure continued appropriateness and safety.<br><br>On 3/20/2024 at 2:20 PM, an interview was a conducted with Rehab Services Director D regarding enabler bar assessments. She reported the therapist will evaluate the resident based on their bed mobility and then make a note if they meet criteria for an enabler bar. They will write a quick summary on a form and place in the maintenance mailbox in addition to completing a request in the electronic maintenance system. Director D was asked if they completed ongoing monitoring for the enabler bars and she stated they do complete quarterly therapy assessment on residents that include a portion on bed mobility. If they found the resident was no longer appropriate for assist bars, they would relay that information to nursing and maintenance. But they are not putting documentation into their quarterly evaluations specifically related to enabler bar assessments.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/21/2024 a review was completed of the facility policy entitled, Restraint Management, last approved 3/7/2023. The policy stated, .When a guest's/resident's condition necessitates consideration for a restraint, alternative intervention must be attempted and documented on the Physical Device Evaluation and in the care plan. A Physical Device Evaluation will be completed prior to initiating a device by a licensed nurse or the interdisciplinary team. The guest/resident, family member or legal representative will be included in the decision process. They will be fully informed of: How the use of the restraint will treat the guest's/residents medical symptoms .The potential risks and benefits of using a restraint (including side rails); alternatives to restraint use .using a physical restraint or side rails must have a current, signed restraint consent in the medical record .Side rails may be used to treat a guest's/residents medical symptom and only after alternatives have been evaluated and found to be inadequate for guest/resident safety. A Physical Device Evaluation will be completed upon initiation . |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471<br><br>Based on observation, interview, and record review the facility failed to collaboratively review mental health documentation, code a Minimum Date Set (MDS) accurately, and add a mental health diagnosis for one resident (Resident #52) of one resident reviewed for behavioral health care, resulting in Resident #52's diagnosis of Schizophrenia not being addressed by the facility until 15 months after admission.<br><br>Findings Include:<br><br>Resident #52:<br><br>During initial tour on 3/18/2024, Resident #52 was observed watching the news in bed. He began to speak about specifics regarding his early adulthood and without hesitation reported he was kidnapped by the facility, and is being kept here against his will. He continued with tangential/hyperverbal speech as this writer listened. He expressed his brother who resided in down state committed suicide but he does not believe that to be true. He owns 41 acres of land and contacted the FBI, NSA, Homeland Security, DEA and other federal agencies allowing them to use it for surveillance or other tasks. He has a defibrillator and upon its expiration he will also expire; his work with abused/neglected children as a Behavioral Psychologist and building 14+ hours in Wisconsin. He then requested this writer contact a lawyer for him. While Resident #52 shared his account he did not appear to be distressed.<br><br>On 3/19/2024 at approximately 11:15 AM, a review was completed of Resident #52's medical record and it indicated he was admitted to the facility on [DATE] with diagnoses that included, Delusional Disorders, Unspecific Psychosis, Anxiety and Schizoaffective Disorder (added on 1/23/2023). Resident #56 is not able to make his own decisions and was appointed a guardian though the courts. Further review was completed of Resident #56 records, and it yielded the following:<br><br>MDS (Minimum Data Set) Assessments:<br><br>Resident #56 diagnosis of Schizoaffective was not coded on his MDS upon his admission to the facility in January 2022. It was not coded on the MDS until March 2023 MDS assessment (15 months after admission).<br><br>Psychiatric Group Progress Notes:<br><br>11/15/2022 at 14:52: .He is in the room lying in bed watching TV. He answer question of depression with no then states I have more education than you, leave. Staff state his mood has been better since medication increased on 10/17/22. 30 day look back shows occasional delusions and paranoia. Staff states he is eating well. No agitation seen in the exam .Perceptual Disturbances: delusions/paranoia .ASSESSMENT & PLAN Paranoid schizophrenia [F 20.0] Plan: add AM dose of Seroquel. Monitor for s/s of psychosis, hallucinations, delusions, paranoia .<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/9/2023 at 14:04: .He is expressing a concern that he is blind in one eye and is frustrated he feels he is held captive. Writer acknowledges pt is in a memory care unit . Pt disregards the information. 30 day chart look back shows one episode of delusions .the doctors at the facility has made him blind. Overall he seems not to be in any distress .Paranoid Schizophrenia Plan: add am dose of Seroquel .<br><br>Level II PASARR:<br><br>2/28/2022:<br><br>Axis I: Paranoid schizophrenia .He was brother to theER on [DATE] after he was found wandering by police and taken to the hospital. He was having delusions, confusions .<br><br>The facility's contracted psychiatric service and local community mental health both supplied documentation that indicated Resident #53 had a Schizophrenia diagnosis and it was not intertwined into his record until over a year after his admission.<br><br>03/19/2024 at approximately 1:00 PM, an interview was conducted with Social Work Director A regarding Resident #53's Schizophrenia diagnosis and his current mental health presentation. Director A explained the resident has fixed delusions around his education, property ownership and carpentry abilities. Prior to his admittance he was living in deplorable conditions and APS (Adult Protective Services) and Law Enforcement became involved. This writer and Director A reviewed the PASARR Level II from 2/2022 which indicated the diagnosis of Paranoid Schizophrenia. The Director explained when the Level II PASARR's are received and have new diagnoses he will provide it to MDS to update in the resident's medical record. He was unsure as to how this was overlooked in 2022.<br><br>On 3/20/2024 at 11:45 AM, an interview was conducted with MDS Coordinator P about addition of diagnoses to resident records. Coordinator P stated Social Services Director A will review their contacted psychiatric services notes and if there is any updated, he will alert her. Coordinator P shared she would not know to look through documentation to ascertain added/ruled out diagnoses if it was not brought to their attention and relies on Director A to alert her. For Resident #52 his diagnoses list was update on 1/23/2023 but not coded on the MDS until 3/2023 due to the lookback period.<br><br>On 3/22/2024, a review was completed of the facility policy entitled, PASARR, revised 11/12/2021. The policy stated, .If a comprehensive Level 2 screening is preformed, the recommendations are to be included in the plan of care if the physician chooses to adopt the recommendations .<br><br>On 3/22/2024, a review was completed of the facility policy entitled, Accuracy of MDS, effective 2/22/2023. The policy stated .Each individual that completes a section of the MDS must verify accuracy of the MDS as specified in by the MDS 3.0 Users manual by: Review of the residents record; Observation of the resident; Communication with the resident, direct care staff, physician, family and licensed professionals; any other route by which information needs to be obtained. Prior to signing or completion of a section of the MDS, the interdisciplinary team must review the MDS to ensure that all information is accurately represents the resident's status as of the Assessment Reference Date . |

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| | 235446 | A. Building<br>B. Wing | 03/20/2024 |

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| Autumnwood of Deckerville | 3387 Ella St<br>Deckerville, MI 48427 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471<br><br>Based on observation, interview, and record review the facility failed to ensure proper communication and collaboration with hospice services was provided to three residents (Resident #13, Resident #46 and Resident #63) of three residents reviewed for hospice services, resulting in facility staff and residents being unaware of their hospice schedule, specific hospice services, delays in receipt of progress notes and the timely uploads of documentation to resident medical records.<br><br>Findings Include:<br><br>Resident #63:<br><br>During initial tour on 3/18/2024, Resident #63 was observed visiting with his wife. His wife share he recently signed onto hospice due to his decline.<br><br>On 3/19/2024 at approximately 10:30 AM, a review was completed of Resident #63's medical records and it revealed he was admitted to the facility on [DATE] with diagnoses that included, Dementia, Alzheimer's Disease, Depression and Mood Disorder. Resident #46 was signed onto hospice services on 2/12/2024.<br><br>Care Plan:<br><br>While the care plan does have mention of Resident #63's receiving hospice services, it does not indicate the specific disciplines, frequency of visits or hospice agency.<br><br>Further review completed of Resident #63's medical records and it showed there was no consistency in facility receipt and uploading of hospice visits notes. There had been no hospice documentation uploaded to his chart since shortly after he signed onto hospice services.<br><br>On 3/20/2024 at 11:20 AM, Nurse B was asked how hospice staff communicate with facility staff upon their arrival. Nurse B stated they check in with the nurses at arrival and prior to them leaving, but they never know when they are coming as there is no schedule provided. Nurse B was asked if there was a hospice book for Resident #63 and she searched for the binder but was unable to locate it on the unit. There were other hospice agency binders that were located but there were no notes from hospice regarding the care provided to those specific residents. Nurse B recalled searching for Resident #46's book last week and being unable to locate and was informed it may be on another unit.<br><br>On 3/20/2024 at 2:40 PM, an interview was held with Social Services Director A regarding facility collaboration and communication with hospice. Director A stated each resident should have their own hospice binder, on their respective unit where hospice staff where document in after their completed visit. They also check in with the nurse upon arrival and prior to leaving. Each hospice agency has a different method of supplying their progress notes to the facility but upon receipt they are scanned into the resident's chart.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This writer and Director A reviewed Resident #63's medical records and saw there were notes from February scanned in, but nothing recent for the resident. Director A was informed the resident's hospice binder was not located on the unit and it was unknown how communication/collaboration occurred when there was no documentation, no calendar, and no indication of which hospice services the resident received. Director A shared he was not aware the binders were not at the nurse's station or that the documents were not being uploaded timely. He expressed understanding of the concern.<br><br>On 3/20/2024 at 3:35 PM, the DON (Director of Nursing) shared she located Resident #63's hospice binder on another unit. She explained the week prior the binder was visualized on the dementia unit for Resident #63, but unbeknownst to facility staff, hospice combined all their patients into one binder and placed the condensed binder on A-Wing.<br><br>On 3/21/2024, a review of the facility policy entitled Hospice Care revised 8/4/2023. The policy stated, . Develop a plan of care that identifies the care and services which the facility and hospice agency will provide in order to be responsive to the unique needs of the resident and their expressed desire for hospice care . Hospice IDT notes related to resident's visits and plan of care are to be maintained in the medical record .<br><br>37771<br><br>Resident #13:<br><br>On 3/18/24 at 2:29 PM, an observation was made of Resident #13 dressed and sitting in his wheelchair in his room. The Resident was interviewed, answered some questions and engaged in limited conversation. The Resident reported having hospice services but did not know the name of the hospice service used, who came to see him and when. When asked about a calendar or communication of who from hospice was coming to visit, the Resident indicated he did not know who or when they were coming, did not have a calendar, and stated, they just come when they come, they just show up, shook his head and reported he did not know who comes or when they come. An observation of the Resident's room revealed no hospice calendar on the walls or on the Resident's tables.<br><br>A review of Resident #13 medical record revealed an admission into the facility on [DATE] with diagnoses that included heart disease, Parkinson's disease, peripheral vascular disease and chronic pain. A review of the Minimum Data Set assessment revealed the Resident had intact cognition, was dependent on staff for activities of daily living of toileting hygiene, bathing, dressing, personal hygiene and transfers, and received hospice services.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/19/24 at 2:43 PM, an interview was conducted with Nurse L who was assigned care for Resident #13. Resident #13's hospice binder was reviewed at the nurses' station. There was no calendar of when hospice staff was scheduled to visit and the notes in the binder did not indicate when the Resident was to be seen next or who was coming. When asked about hospice nurse visits, the Nurse indicated she thought the nurse came on Tuesday and Fridays, did not have a CNA that came, and got massage therapy, but reported she did not know when they come for the massages. The Nurse reviewed the hospice binder and reported she did not see when they will be here or when the next massage was. The hospice care plan was in the binder that indicated a social worker, and a clergy person were to see the Resident once every 2 weeks but did not give a day for the visit. It was discussed with the Nurse that the Resident had communication of the visits, he would be able to anticipate the hospice staff coming. The Nurse reported she did not see in the hospice binder for Resident #13, a calendar or information on when the hospice staff would be visiting.<br><br>Resident #46:<br><br>A review of Resident #46's medical record revealed an admission into the facility on [DATE] and readmission on 1/4/24 with diagnoses that included dementia, metabolic encephalopathy, pressure ulcer of right heel, and diabetes. A review of the Minimum Data Set assessment dated [DATE], revealed the Resident had severely impaired cognitive skills for daily decision making and was dependent of care of activities of daily living. The Resident was under hospice services.<br><br>On 3/18/24 at 1:48 PM, an observation was made of Resident #46 lying in bed, awake. The Resident was asked questions, but the Resident did not respond with answers and did not engage in conversation. An observation was made of enteral nutrition hanging on a pole with tubing that was in a controller, turned off and not infusing at this time. The enteral nutrition was labeled as Glucerna and had the Resident's name and date on it.<br><br>On 3/20/24 at 11:40 AM, staff at the Nurses' Station on the 100 hall was asked for Resident #46's hospice binder, but the Nurse was unable to locate the binder and indicated that it would be at the other Nurses' Station where Unit Manager V was at.<br><br>On 3/20/24 at 11:43 AM, an interview was conducted with the Unit Manager V regarding Resident #46. The Unit Manager was asked for the Resident's hospice notebook but was unable to find the hospice notebook. The Unit Manager indicated the Resident might not have a notebook and that hospice notes would be uploaded into the electronic medical record.<br><br>On 3/20/24 at 1:11 PM, a review of Resident #46's medical record revealed no hospice notes for the month of March or a calendar to indicate when hospice staff would be coming to the facility for visits.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/20/24 at 1:57 PM, an interview was conducted with the Director of Nursing (DON) and Administrator (NHA) regarding coordination of care for residents receiving hospice care. A review of Resident #46's medical record revealed a lack of documentation of hospice communication/notes of visits made from Resident #46's hospice services. The DON and NHA indicated that the hospice was to leave the notes, but after review of the medical record, indicated they have not been scanned in. When asked about coordination of care and when the staff come to visit, the DON indicated they did not have a calendar for Resident #46. A review of Resident #13's concern of not knowing when hospice staff/services take place during the week, the DON indicated the hospice nurse comes on Tuesday and the Resident gets a massage on Thursday but indicated she had not gotten a calendar prior to yesterday. The DON indicated she had received a calendar for March and April. When asked they just sent the March calendar the DON stated, yes. |