STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235502	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ch Rehab & Nurs Cnt - Commons Dearborn	16391 Rotunda Dr Dearborn, MI 48120

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to ensure a catheter bag (a collection device for urine) was not visable to others for one (R262) of one resident reviewed for dignity with catheter usage, resulting in the R262's dignity not being preserved and the potential for the feelings of embarrassment. Findings include: On 2/27/2024 at 11:09 a.m., R262 was observed sitting in a wheelchair with a foley catheter anchored behind the wheelchair visible from the doorway. R262's foley catheter bag was observed with bloody urine. During an interview with R262 regarding the uncovered foley catheter bag, R262 stated, Yes, I would like to have my foley catheter bag covered. They don't do what they supposed to do around here. Why wouldn't I get one. On 2/28/2024 at 2:22 p.m., R262 was observed sitting in a wheelchair with a foley catheter bag anchored behind the wheelchair with amber colored urine inside the bag. On 2/28/2024 at 2:30 p.m., Licensed Practical Nurse (LPN) H was interviewed regarding the foley catheter bag not having a privacy cover. LPN H said, all residents should have a covering over the catheter bags to preserve dignity. According to the medical record, R262 was admitted to the facility on [DATE] with diagnoses of retention of urine and congestive heart failure. The medical record review revealed R262 was also oriented to person, place, and time and able to make needs known. Review of the 2/27/2024 Foley Catheter care plan documented, I have an alteration in the urinary tract as evidenced by Foley Catheter related to urinary retention. -Interventions: Store drainage bag inside a protective dignity pouch. On 2/29/2024 at 3:15 p.m., the Director of Nursing (DON) was interviewed regarding a covering for residents with foley catheter bags. The DON confirmed that residents with foley catheters should have a covering to prevent others from observing the content of the foley bag.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview, and record review, the facility failed to ensure the resident and the legal representative formulated an Advance Directive to grant and/or withhold life sustaining treatment (Cardiopulmonary Resuscitation/CPR, Artificial Nutrition/Peg Tube, Artificial Hydration/ IV, and Diagnostic Testing) according to their wishes upon admission for two residents (R314 and R59) of 14 sampled residents reviewed for advance directives, resulting in the potential of denial of the resident's right to have life sustaining or withheld decisions honored. Findings include: R314 On [DATE] at 2:00 PM review of the Electronic medical record (EMR) revealed resident did not have documentation of an advance directive being initiated since admission into the facility. Record review of the EMR revealed R314 was admitted into facility on [DATE] with pertinent diagnoses of chronic respiratory failure, chronic obstructive pulmonary disease. Review of the EMR revealed R314 was alert and oriented x3 (person, place, and time) indicating intact cognition. R314's EMR facesheet did not indicate a code status. Review of the nurse's station advance directive binder did not include advance directives for R314. On [DATE] at 3:00 PM R314's advance directives were requested. Review of Physician orders revealed R314 did not have an order for code status as of [DATE]. On [DATE] at 10:52 AM in an interview with Social Worker I when queried when should advance directives be completed for new admissions, SW I said usually within two to three days at the initial care conference. SW I did not provide a response when asked about the delays of obtaining completed advance directives. R59 Record review of the EMR revealed resident had no documentation of an advance directive being signed by either R59 or the Durable Power of Attorney (DPOA) since readmission into facility. Record review of the EMR revealed R59 was admitted into facility on [DATE] with most recent readmission on [DATE] and expired in the facility on [DATE] with a pertinent diagnosis of sepsis, pneumonia, adenocarcinoma. According to the Minimum Data Set (MDS) dated [DATE], R59 had severe cognitive impairment. On [DATE] at 2:38 PM, SW I was interviewed and said there were no facility signed advance directives for R59. When queried what was R59's code status prior to most recent hospitalization in December of 2023 SW I revealed R59 was a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advance Directives from R59's hospital stay in December of 2023 revealed R59's DPOA signed a DNR. On [DATE] at 2:45 PM, DPOA J was interviewed and revealed that he did intend for R59 to remain a DNR upon readmission to the nursing facility but did not sign a facility advance directive to confirm code status. Review of the facility policy titled Advance Directives effective [DATE] revealed in part . Procedure the admission department will provide to the resident or responsible party upon admission the facility's information packet on Advance Care Directives. Resident will remain 'full code' until all paperwork is in place. Social services will follow up with the resident, DPOA. Social worker will fax a copy of the Advance Directive into the EMR and update the resident face sheet. The resident's attending physician will be informed of the Advance Care Directive and a physician's order will be written in the EMR.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review the facility failed to ensure a safe wheelchair transport for one (R15) of seven residents reviewed for accident hazards, resulting in a fracture with subsequent wound, pain, and decreased activities of interest due to the inability to participate. Findings include: On 2/27/2024 at 9:58 AM R15 was observed in bed wearing a hospital gown. R15's heel boots were observed on R15's wheelchair. When R15 was asked the purpose of the heel boots, R15 stated, The boots are for my feet when I sit in my wheelchair, so my feet don't slip off the footrests. When asked have your feet slipped off the foot rests, R15 replied, Yes I broke a bone and now I can't get up. My ankle hurts. When asked what happened to her left ankle R15 replied, Activities (staff) were bringing me back to my room and my left boot fell off the footrest and pulled my ankle and foot. That was the most painful thing I have had to put up with. The bad part is I can't get out of bed now because I'm waiting for this boot (surgical boot) to protect my foot. I'm sick of lying in this bed. I haven't been able to get up or go to activities. Record review of electronic medical records revealed R15 was admitted into the facility on [DATE] with recent readmission on 12/27/2023 with a pertinent diagnosis of acute respiratory disease, pneumonia due to coronavirus, dependence on supplemental oxygen and changes in skin texture-chronic skin tear cox/crease. According to the Minimum Data Set (MDS) dated [DATE], R15 had intact cognition with a Brief Interview of Mental Status (BIMS) of 15/15 and was dependent for mobility. Record review of the Incident and Accident report dated 2/28/2024 revealed the following: On 2/6/2024 at 3:19 PM Resident A&Ox3, verbal -able to make needs known. Resident reported feels she hyperextended her L ankle, during ride in wheelchair being brought back to room by activities-foot slipped off footrest and bent downward under chair. Due to pain resident MD notified-Xray ordered via STAT. Oncoming Nurse made aware. On 2/7/2024 at 1:18 AM Left ankle x ray results faxed over. Impression: A fracture of the distal fibula. MD ordered Motrin 400 mg BID PRN for Resident due to pain/soft tissue swelling. On 2/29/24 at 8:26 AM, Activities Supervisor (AS) D was interviewed and stated While I was pushing (R15) back to her room her left foot and foam boot fell off the footrest. (R15) immediately yelled out in pain I stopped pushing her and called for the nurse. (Licensed Practical Nurse (LPN) E) was at the nurse's station and took over. AS D further revealed R15 has not participated in activities since the ankle injury on [DATE]th 2024 and that R15 did not express any left foot and/or ankle pain prior to her foot slipping off the footrest. When queried was R15's foot properly secured prior to transport, AS D, stated I don't know we (activities staff) don't transfer residents into wheelchairs we only transport them. (R15) was already in the wheelchair when she came to activities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/29/24 at 9:44 AM, LPN E was interviewed and said she heard R15 yell while AS D was pushing R15 back to the room. LPN E saw R15's left foot boot was caught underneath the footrest and pulled directly onto the left foot and R15 was weeping. LPN E stated, I fixed the boot reapplied the Velcro strap and repositioned (R15's) left foot on the footrest. On 2/29/24 at 10:48 AM, LPN F was interviewed and said she was working on 2/6/2024 and heard R15 yell while being pushed in the wheelchair and observed the left foot off the footrest and left foam boot underneath the wheelchair. LPN F stated I assessed (R15's) ankle. (R15) was complaining of ankle pain so I called the doctor to get an xray. On 2/29/24 at 11:01 AM, Rehab Director G was interviewed and revealed R15 was seen by therapy services for wheelchair positioning in [DATE] due to R15's feet falling off the footrest during transportation. Therapy got R15 a wider wheelchair and adapted footrests (heel boots secured by Velcro straps to the wheelchair foot rests). Record review of the Occupational Therapy Discharge Summary dated 10/22/23 revealed 26-inch WC (wheelchair) provided Bil leg rests adapted for comfort and positioning, leg rests and foot buddy provided . Record review of R15's care plan revealed Problem date: 10/17/2023 R15 requires a 26-inch wheelchair with adequate feet support in order to optimize comfort and safety which would allow her to attend activities of choice. Record review of the wound care practitioner note dated 2/19/2024, revealed The patient has a new left ankle fracture x 1week. Consequently, her mobility has been significantly limited and she has developed increased edema in the left lower leg which has led to the formation of new blood blister x 1 week duration. Record review of the Physical Medicine and Rehab Progress Note, dated 2/8/2024, revealed in part . R15 was seen today to follow up on pain control. Unfortunately, in the interim (R15) had an event in which her foot slipped off the footrest while being transported on a wheelchair, and (R15) subsequently had acute left ankle pain. X-ray was completed which revealed a distal fibula fracture . (R15) is complaining of left ankle pain throughout the lateral and medial aspect. Pain elsewhere is stable and forgotten due to acute pain. (R15) is now agreeable to increase the frequency of tramadol (pain medication). On 2/29/24 at 11:33 AM the Director of Nursing (DON) was interviewed and agreed that R15's left fibula fracture was caused by R15's foot slipping off the footrest during wheelchair transportation and that staff should make sure R15's foot boots are secure prior to transport. Review of the facility policy titled Wheelchair Transport (undated) revealed in part . Ensure the resident's feet are on the leg rest, If the resident seating position changes or feet are not properly on the footrest, the person pushing the wheelchair should: 1. Stop pushing the wheelchair. 2. Reposition the resident to ensure safety. 3. Once the resident is positioned safely, continue transport.

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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. 32000 Based on observation, interview, and record review the facility failed to maintain sanitary conditions in the kitchen and its support spaces resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting the facility's total census of 76 residents. Findings include: 1. On 2/27/24 at 10:21 AM, the IL kitchen dish machine was observed by the surveyor being tested by Assistant Dining Director, staff B, via a temperature sensing plate. Upon the dish machine's cycle finishing the surveyor asked staff B what the final rinse temperature read to which they replied, 160 degrees F. At this time the surveyor inquired with staff B on what they would normally do in a situation like this to which they replied, test it again. On 2/27/24 between 10:23 AM - 10:32 AM, two additional tests were conducted by staff B on the dish machine via a temperature sensing plate revealing the same temperature reading as the original test. At this time Dining Services Director, staff A, stated, I'll call maintenance to contact the service company. We will use the 3-compartment sink to sanitize until we can get this fixed. On 2/28/24 at 1:41 PM, upon record review of a policy titled, dish machine temperature record (high temperature machine) dated, February 2024 revealed numerous dates that the final rinse temperature did not reach 180 degrees F upon testing, but were signed off on by staff via initialing under the checked by column. Further review of this document by the surveyor revealed that the column titled, manager weekly review was left blank throughout the document. Review of 2017 U.S. Public Health Service Food Code, Chapter 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures, directs that: (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90oC (194oF), or less than: Pf (1) For a stationary rack, single temperature machine, 74oC (165oF); Pf or (2) For all other machines, 82oC (180oF). Pf 2. On 2/27/24 at 10:10 AM, a utensil holding container was observed with an accumulation of dust and dried food debris on its interior in the IL kitchen. On 2/27/24 at 10:11 AM, upon interview with Dining Services Director, staff A, regarding the current state of the utensils and their container they stated, we keep cleaning logs, and this is part of a regular task for us. At this time the surveyor requested a copy of the cleaning logs mentioned by staff A to review. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/27/24 at 11:07 AM, seven water pitchers were observed with heavy sticker residue on their exterior surface while stored on the clean ready for use storage rack in the health center. At this time the surveyor inquired with staff A on the facility's expectation on the condition of equipment and utensils prior to being placed on this storage rack to which they stated, all labels and stickers should be fully removed before being placed on this rack. On 2/27/24 at 11:37 AM, the B unit's nourishment rooms refrigerator and freezer were observed in a soiled state with an accumulation of dust and debris on its interior. On 2/27/24 at 11:45 AM, the A unit's nourishment rooms refrigerator, freezer, and microwave were observed in a soiled state with an accumulation of dust and debris on each piece of equipment's interior. Upon observation the surveyor inquired with Assistant Dietary Manager, staff B, on who is responsible for the cleaning of the equipment in the nourishment rooms to which they replied, the nursing staff should be letting someone know when they get like this. On 2/28/24 at 10:13 AM, review of electronic documents dated 1/9/24, titled Master Cleaning Schedule revealed that the facility has a system in place to ensure a clean and sanitary environment in the kitchen. Review of 2017 U.S. Public Health Service Food Code, Chapter 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, directs that: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 34901 This citation has three deficient practices. Deficient practice #1. Based on interview and record review, the facility failed to establish a comprehensive Infection Control Program that conducted annual review of policies/procedures and calculated monthly facility acquired infection (FAI) rates, resulting in the potential for staff to be unaware of current national standards of practice for infection control and prevention and missed opportunities to identify trends in FAI, resulting in the potential delay in implementing corrective actions. Findings include: On 2/29/24 at 9:21 AM, the facility's infection control program was reviewed with the Infection Preventionist (IP) and revealed the following: 1. The IP acknowledged that the following documents had not been reviewed at least annually to ensure they were current and in keeping with national standards of practice: - List of communicable diseases to report titled, Type and Duration of Isolation was last updated 8/29/2017. - Policy titled, Influenza & Pneumococcal, dated August 2019. - Policy titled, Isolation - Categories of Transmission-Based Precaution, last reviewed August 2022. - Policy titled, Standard Precautions, last reviewed May 2022. - Policy titled, COVID-19 Multi-Transmission, last reviewed May 2022. - Policy titled, COVID-19 Staff and Resident Testing, last reviewed 1/9/2022. 2. The IP provided no calculations of monthly FAI rates which could be used to determine trends of infections from month to month and to implement timely corrective measures for spikes in rates. The IP stated, I have never compared the difference in month-to-month infections. The IP said that there needs to be more concrete documentation of the analysis of infection trends. On 1/29/24 at 2:09 PM, during an interview and record review with the Director of Nursing (DON), the outdated policies as indicated above were reviewed. In response, the DON stated, So noted. The DON added that the percentages in terms of the FAI rates, quantify the changes in FAI from month to month. The DON stated, It's important to show progress or where education is needed. 47964 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Deficient practice #2. Based on observation, interview, and record review the facility failed to properly store a nebulizer mask and tubing between resident use for one (R314) out of three residents reviewed for respiratory care resulting in the potential for increased risk of respiratory infections. Findings include: On 2/27/24 at 10:41 AM, R314's nebulizer mask was observed lying directly on the nightstand not stored in a bag. When R314 was asked do you use the nebulizer, R314 responded, I use the nebulizer 2-3 times per day, the nurse adds the medicine, but I do the treatment on my own. On 2/27/24 at 1:06 PM, observed the nebulizer mask lying directly on nebulizer machine not stored in a bag. On 2/28/24 at 8:28 AM observed the nebulizer mask lying directly on nebulizer machine not stored in a bag. Record review of Electronic Medical Records (EMR) revealed R314 was admitted into facility on 2/24/2024 with pertinent diagnoses of chronic respiratory failure, chronic obstructive pulmonary disease. R314 had intact cognition. On 2/29/24 at 11:12 AM the Director of Nursing (DON) was interviewed and acknowledged nebulizer masks should be stored in a bag. 49103 Deficient Practice Statement #3 Based on observation, interview, and record review the facility failed to perform hand hygiene between care for residents (R318, R39, and R312), resulting in the potential for the transmission of communicable diseases and infections. Findings include: On 02/28/24 at 9:47 AM Licensed Practical Nurse (LPN) F was observed to prepare and administer medications to R318. LPN F did not wash or sanitize hands following administration of oral medications. LPN F donned gloves to administer eye drops to R318. LPN F did not wash hands after removing the gloves and did not wash or sanitize hands prior to leaving the room. On 2/28/24 at 9:54 AM, without performing hand hygiene, LPN F was observed preparing medications for R39. LPN F administered the medications to R39. LPN F did not wash or sanitize hands prior to administration of medication and did not wash or sanitize hands prior to leaving the room. On 2/28/24 at 10:06 AM, without performing hand hygiene, LPN F was observed preparing medication for R312. LPN F administered the medications to R312. LPN F did not wash or sanitize hands prior to giving the medications and did not wash or sanitize hands prior to leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/28/24 at 10:10 AM, LPN F was queried about hand hygiene practices. LPN F said there was no sanitizer on the medication cart because it had been loaned to another nurse passing medication. LPN F acknowledged that hand hygiene should be performed before and after medication administration for each resident. On 2/29/24 at 12:38 PM the Director of Nursing (DON) was interviewed and said the policy of the facility is to wash hands between each resident. The DON stated, I stand by the policy. Review of the facility policy last reviewed May 2022, titled, Infection Prevention Policy: Hand Hygiene states in part: Facility staff shall wash their hands after each direct resident contact when indicated to prevent the spread of infection from one resident to another. And under Hand Hygiene Guidelines which states in part Gloves are never a substitute for handwashing. Hands must be washed every time gloves are removed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to ensure two residents (R17 and R31) out of five residents reviewed for immunizations, were currently educated and offered a pneumonia immunization, resulting in the potential for development and spread of pneumonia among vulnerable residents in the facility. Findings include: On 2/29/24 at 2:10 PM during an interview and record review with the Director of Nursing (DON), the following residents did not have documentation of a current pneumococcal immunization or refusal: - The Electronic Health Record (EHR) for Resident #17 (R17), most recently admitted on [DATE] and was over [AGE] years of age, documented the pneumococcal vaccine was offered on 10/26/20 and it was declined. No other offer for pneumococcal immunization was documented. - The EHR for Resident #31 (R31), most recently admitted on [DATE] and was over [AGE] years of age, provided no documentation that pneumococcal education and/or immunization was offered or refused. On 2/29/24 at 3:05 PM, the DON stated regarding R17, I guess we can offer the pneumo vaccine every year. The facility provided no documentation that the pneumococcal vaccine was contraindicated for R17 or R31. A review of the facility's policy titled, Influenza & Pneumococcal, dated August 2018, .pneumococcal vaccination are offered year round .(Staff are to) assure documentation in the resident's medical record of the information/education provided regarding the benefits and risk of immunization and the administration or refusal of or medical contraindications to the vaccine

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47964 Based on observation, interview, and record review, the facility failed to ensure the first-floor shower room was maintained in a clean and sanitary manner, resulting in the residents' environment not being homelike and the potential for spread of harmful pathogens. This deficient practice has the potential to affect all 27 residents who reside in rooms 125 to 145. Findings include: On 2/27/2024 at 10:08 AM, the following observations were made of the shower room used by residents in rooms 125-145, a bag of used and soiled towels were on the floor and left on a cart in the shower room. On 2/28/2024 at 9:00 AM in an observation of the shower room with Certified Nursing Assistant (CNA) K revealed trash on the floor drain, soiled towels lying on a cart, used empty shampoo bottles left on the grab bars in the shower room. CNA K stated that there should not be soiled towels and garbage left after giving a resident a shower. On 2/29/2024 at 11:15 AM, the Director of Nursing (DON) was interviewed and revealed that the shower room should be cleaned after each use it and should not be left soiled. On 2/29/2024 at 11:30 AM a facility shower policy was requested and was not provided by survey exit (2/29/2024).