| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235515 | A. Building<br>B. Wing | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeview Manor Healthcare Center | 408 N Fifth Ave<br>Tawas City, MI 48763 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>39059<br><br>Based on observation, interview and record review, the facility failed to reconcile narcotics during medication/narcotic key exchanges and ensure that narcotic reconciliation was completed accurately for two of two medication carts reviewed, resulting in scribbled over narcotic totals/numbers with the likelihood of narcotic diversion going unnoticed.<br><br>Findings include:<br><br>On 4/03/24, at 10:22 AM, the Director of Nursing (DON) was asked to explain the narcotic reconciliation process for the facility. The DON explained that two nurses sing for the narcotic delivery, place the narcotics in the locked drawer in the medication carts. The DON was asked when the narcotics are reconciled and the DON stated, when placing them in the medication cart and at shift change.<br><br>A record review of the CONTROLLED SUBSTANCE SHIFT INVENTORY 200/300 narcotic reconciliation document revealed on 4-1-24 0700 . TOTAL # of Rx's at Start of Shift there was a total of 71. The column labeled Received from Pharmacy has a +1 with two sets of initials in the box. The column labeled Empty or to DON revealed -1 with two sets of initials and it appears to be a -4 written over top of nurse initials. The column labeled (=) Total at End of Shift revealed 71 crossed off with a 67 written next to it.<br><br>A review of 4-2-24 the column labeled Time appeared to have 0700 and had scribbled numbers over top and the time written was not legible. The column labeled Total # of Rx's at Start of Shift had 68 with 67 written overtop. The column labeled Received from Pharmacy was left blank. The Empty or to [NAME] had the number 1 written down with scribbles overtop and was not legible. The column labeled (+) Total at End of Shift had 67 written down overtop of what appears was a 68.<br><br>A review of 4-2-24 1030 Total # of Rx's at Start of Shift revealed 67 or 68 the exact total was not legible. The column labeled Received from Pharmacy was left blank. The column labeled (=) Total at End of Shift had 67 with 66 written over top.<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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the CONTROLLED SUBSTANCE SHIFT INVENTORY 100/400 narcotic reconciliation document revealed TIME 1800 the date was not legible. The column labeled Total # of Rx's at Start of Shift revealed 68 with 67 written overtop. The column labeled Received from Pharmacy revealed +7 with two sets of initials. The column labeled revealed -1 and the column labeled (=) Total at End of Shift revealed a total that was not legible. It appeared as 73 with a number 1 written close to the number 3 that made it appear as if it was a number 4. There were scribbled over numbers on numerous lines/dates: 3-20-24 . 3-23-24 . 3-27-24 . 4-2-24.<br><br>On 4/03/24, at 3:15 PM, The DON was asked for an interview with Nurse A and the DON offered that she was out on break. Nurse Manager (NM) B approached and offered assistance with a skin observation on a resident. NM B pulled out a set of keys from their pocket and handed them to the DON. UM B was asked if the keys were (Nurse A's) and UM B stated, yes. UM B was asked if (Nurse A) was on break and UM B stated, I assume so.<br><br>On 4/03/24, at 3:26 PM, During medication storage task with the DON, it was observed with the full set of keys for the 100/400 medication cart. The DON was asked if (Nurse A) was back from break yet and the DON stated, not yet. The DON was asked if the keys they used to open the medication cart were (NurseA's) keys and the DON stated, that UM B handed them off to her as they were unsure how long Nurse A would be on break. The DON further offered that they were protecting them and usually when nurses go on breaks, they give their medication cart keys to a manager.<br><br>On 4/3/24, at 3:45 PM, Nurse A was observed walking towards their medication cart and was asked if they usually had a manger hold onto the medication cart keys while on break and Nurse A stated, when they leave the building for breaks they have to. Nurse A was asked if they had reconciled the narcotics when they received the keys back from the manager and Nurse A stated, no. Nurse A was asked if they had reconciled the narcotics prior to handing over the narcotic keys and Nurse A stated, no but could do it at that time. Nurse A was asked how could they ensure the safety of the stored narcotics and how would they know if either the DON or UM B had taken narcotics from the medication cart and Nurse A did not answer but offered that they could count narcotics at that time.<br><br>A review of the CONTROLLED SUBSTANCE SHIFT INVENTORY 100/400 narcotic reconciliation document revealed that Nurse A had reconciled at 7 am and had written down the next time to reconcile was PM. There were no reconciliation's noted for the narcotic key exchanges from Nurse A to UM B back to the DON and then back to Nurse A.<br><br>A review of the facility provided policy Controlled Substances . Last Revised 10/26/2023 revealed . All controlled substances will be stored in the medication cart. The medication cart and controlled substance drawer will always be locked when not within view of the nurse who is responsible for the cart . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>39059<br><br>Based on observation, interview and record review, the facility failed to alert staff and visitors of Enhanced Barrier Precautions in a timely manner and follow Enhanced Barrier Precautions during a medical treatment for one resident (Resident #18), resulting in wound care being completed with no gown and the likelihood of cross contamination and spread of infections causing bacteria.<br><br>Findings include:<br><br>Resident #18:<br><br>On 4/02/2024, at 9:30 AM, Resident #18 was resting in their bed. There was no isolation caddy nor sign on the door.<br><br>On 4/02/2024, at 2:30 PM, a record review of Resident #18's electronic medical record revealed a readmission on 07/27/2023 after a short hospital stay with diagnoses that included Diabetes, weakness and Dementia. Resident #18 required extensive assistance with Activities of Daily Living (ADL's) and had severely impaired cognition.<br><br>A review of the Physician orders revealed an order for Enhanced Barrier Precautions Start Date: 03/26/2024.<br><br>A review of the care plan (the resident) is on Enhanced Barrier Precautions related to: chronic wound Date Initiated: 03/29/204 . Prophylactic prevention of spreading an infection to the wound: Enhanced Barrier Precautions . Interventions Gloves, gown, alcohol-based sanitizer (masks and face shields if needed), readily available for high-contact resident care Date Initiated: 03/29/2024 .<br><br>On 4/03/24, at 10:00 AM, Upon entering Resident #18's room, there was still no isolation caddy, gowns or sign on the doorway. Resident #18 was assisted to their reclining Broda chair with the assistance of CNA C and CNA D. Resident #18 did not have a dressing to their right foot and their pressure ulcer was exposed. CNA C offered that they had just assisted with a shower and that the nurse was headed in to put the dressing back on. CNA C positioned Resident #18's right foot for observation. There was an open wound to outside lateral right foot measuring approximately 1 centimeter (cm) wide by 1.5 cm long. The edges surrounding the ulcer appeared dried, yellow with a callus like appearance. There was an approximate depth of 0.5 cm to the center of the wound.<br><br>On 4/03/24, at 10:27 AM, Nurse A entered Resident #18's room with wound care supplies. Nurse A was concerned that it was a new wound as the CNA had reported it was the toe. Nurse A cleansed and treated the existing pressure ulcer to the right lateral foot per the physician order. Nurse A was wearing gloves and no gown.<br><br>On 4/04/24, at 9:08 AM, Resident #18 was on lying on their back in bed. There was an isolation caddy to the doorway filled with PPE including gowns. |