| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235547 | A. Building<br>B. Wing | 08/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakepointe Senior Care and Rehab Center, L L C | 37700 Harper Avenue<br>Clinton Township, MI 48036 |

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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** 46956<br><br>Based on observation, interview, and record review, the facility failed to maintain the dignity of one (R101) of six residents reviewed for dignity. Findings include:<br><br>Review of the facility record for R101 revealed an admitted [DATE] with diagnoses that included Heart Failure and Dementia. The record also indicated R101 was legally blind.<br><br>On 08/06/24 at 10:38 AM, R101 was observed laying in bed and it was noted a list of hand written care instructions were posted above the head of the bed. The first item on the list stated He is a feeder.<br><br>On 08/07/24 at 11:51 AM, R101 was observed in their room and the sign above the head of the bed stating He is a feeder remained in place.<br><br>On 08/08/24 at 10:14 AM, R101 was observed laying in bed and the sign stating He is a feeder remained posted above the head of the bed. R101 was asked about the signs and stated I don't know what they are.<br><br>On 08/08/24 at 1:42 PM, the facility Director of Nursing (DON) reported they were not aware of the sign referring to the resident as He is a feeder. The DON reported their expectation is that type of wording would not be used or posted.<br><br>A facility policy addressing resident dignity was requested but not received. The facility did provide the document Know Your Rights - Your Medicaid Care and Coverage in a Nursing Facility. This document included the section Quality of Your Medical Care which included the entry These services must be provided in a confidential and dignified manner . |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207<br><br>Based on observation, interview, and record review the facility failed to implement care plan interventions for three residents (R40, R108 and R482) of six reviewed for care planning. Findings include:<br><br>On 8/6/24 at 9:49 AM, R40 was interviewed regarding the care and services they were receiving at the facility and indicated that they had experienced multiple falls at the facility.<br><br>A review of R40's electronic medical record (EMR) progress note section revealed the following, 5/25/2024 23:13 (11:13 PM) Nurses: [R40] said [they] fell on the floor trying to get a cake from [their] roommate's daughter's boyfriend. Nurse and aide did not [witness] the fall. Roommate's granddaughter witnessed the fall. [They] said [R40] fell on the floor trying to [get] cake. They said [R40] fell on [their] back, but did not hit [their] forehead. [R40] told the writer and the aide [they] fell on the floor and hit [their] forehead, but later said [they] did not hit [their] forehead, but rather the back of [their] head. Witness said [R40] fell on the floor, but did not hit the back of [their] head.<br><br>A review of an incident and accident (I/A) report involving R40 dated 5/25/2024 22:44 (10:44 PM) indicated that [R40] had a fall in their room witnessed by their roommate's sister. Per the I/A resident assessments were completed and vitals were taken. No injuries indicated. Resident Description: I fell but did not hit my head. 5/30/24 IDT (Interdisciplinary Team) met to review and concur .Intervention: Medication review by physician.<br><br>A review of R40's fall care plan interventions revealed the following, Interventions .Physician to review medication administration post fall, assess 6[00 AM] medications given concurrently. Date Initiated: 12/04/2023. Post fall 12/12/23: antihypertensive medication reviewed my MD (Medical doctor), d/c (Discontinue) Metroprolol. Check orthostatic BP (Blood pressure) Bid (Two times a day) x 3 days and report abnormal results to physician. Date Initiated: 12/12/2023. Further review of R40's fall care plan revealed there was no documented intervention following R40's fall on 5/25/24.<br><br>A further review of R40's EMR revealed psychiatric visit documentation provided by [Psychiatric provider agency] which indicated that R40's psychotropic (mental health) medication was reviewed by the psychiatric provider on 6/21/24. There was no observed documentation in R40's record which indicated the physician had reviewed R40's prescribed medication following their fall on 5/25/24.<br><br>R40's EMR revealed R40 was most recently admitted to the facility on [DATE] with diagnoses which included Anemia (deficiency of red blood cells) and Muscle weakness. R40's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R40 had an intact cognition and was independent-required partial assistance for all activities of daily living (ADLs).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/7/24 at 2:20 PM, the Director of Nursing (DON) was interviewed regarding their expectations for recommendations being implemented and followed, and new interventions being placed on a resident's care plan following a fall and indicated the expectation was recommendations be, Implemented and followed up on. The DON was further interviewed regarding implementation of the recommendation following R40's fall on 5/25/24. The DON confirmed the physician did not document their review of R40's medication per the recommendation.<br><br>50223<br><br>R108<br><br>On 08/06/24 at 9:23 AM, 10:17 AM, 10:40 AM, 12:20 PM, 08/06/24 at 12:21 PM, and 2:59 PM, R108 was observed lying in bed. R108's heels were observed to be resting directly on the bed. Heel protector boots were observed in a wheelchair behind the door in the room. R108's call light was observed hanging on wall above the head of the bed out of the residents reach.<br><br>On 08/07/24 at 8:30 AM, R108 was observed in bed. Heel protector boots were observed in the corner of the room. R108's call light was still hanging on the wall above R108's head of their bed out of reach.<br><br>On 08/07/24 at 10:34 AM, 11:55 AM and 2:59 PM, R108 was observed lying in bed. The heel protector boots were observed in the closet. R108's call light was observed hanging on the wall above the head of their bed out of their reach.<br><br>On 08/07/24 at 4:04 PM, R108 was observed lying in bed. Heel protector boots were observed still in R108's closet. R108 was asked if they were supposed to wear heel protector boots when they're in bed. R108 stated, yes. R108 was asked if they wore them at all today. R108 stated I don't think so. R108's call light was observed hanging on the wall above the head of their bed out of their reach.<br><br>On 08/08/24 at 8:01 AM, R108 was observed in bed. Heel protector boots were observed to still be in the closet. R108's call light was observed hanging on the wall above the head of their bed out of reach.<br><br>On 08/08/24 at 8:47 AM, during an interview, certified nurse assistant (CNA) D was asked if R108 was supposed to wear heel protector boots while in bed. CNA D responded they have never noticed R108 to have boots on.<br><br>On 08/08/24 at 9:00 AM, during an interview CNA A was asked if R108 is supposed to be wearing heel protector boots. CNA A stated yes. CNA A was observed to look at R108 then look around room and in closet. CNA A was then observed applying the heel protector boots. CNA A was asked if R108 was supposed to have a call light. CNA A stated, yes. CNA A was observed to look at R108's call light hanging on the wall and then placed it on R108's bed within their reach.<br><br>A review of R108's record revealed they were admitted to the facility on [DATE] with a diagnosis of acute on chronic congestive heart failure and acute on chronic respiratory failure, unspecified dementia. A review of the minimum data set (MDS) revealed a Brief interview for mental status (BIMS) score of 6 indicating cognitive impairment.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of R108's care plan revealed the following interventions: BLE soft boots on during the day to prevent contracture; Call light accessible<br><br>R482<br><br>On 08/06/24 at 10:08 AM, R482 was observed in bed. R482's heels were observed resting directly on the bed. One heel protector was observed across the room in R482's (medical recliner) chair. R482's call light was observed on the floor next to their bed out of their reach.<br><br>On 08/06/24 at 12:28 PM and 08/06/24 at 2:29 PM, R 482 was observed in their chair with their heels resting directly on the chair cushion.<br><br>On 08/07/24 at 8:25 AM, A heel protector was observed on R482's right foot only. R482's left heel was observed resting directly on the bed.<br><br>08/07/24 at 10:38 AM, 11:57 AM, and 1:08 PM, A heel protector was observed on R482's right foot only. R482's left heel was observed resting directly on the bed. R482's call light was observed on their bed by the pillow not in reach.<br><br>08/07/24 at 2:26 PM, and 4:15PM, R482 was observed lying in bed. A heel protector was observed on R482's right foot only. R482's left heel was observed resting directly on the bed.<br><br>On 08/08/24 at 8:05 AM, R482 was observed lying in bed with heels resting directly on bed.<br><br>On 08/08/24 at 8:58 AM, during an interview in R482's room CNA A was asked if R482 was supposed to be wearing heel protectors. CNA A stated yes CNA A was asked if they are supposed to be on both feet. CNA A stated both, because (their) not moving. CNA A was asked if R482 repositions themselves at all. CNA A stated I'm not very familiar with (them) but just by looking at (them) I'd say not enough, and we should be doing it. I'll go down and get (them) some heel protectors.<br><br>On 8/8/24 at 1:02 PM, R482 was observed in their chair on their back with their heels resting directly on the chair cushion.<br><br>A review of R482's record revealed they were admitted to the facility on [DATE] with diagnosis of cerebral infarction due to embolism of right cerebellar artery. A review of the MDS revealed a BIMS score of 00 indicating cognitive impairment.<br><br>A review of R482's care plan states: assist me with floating my heels. Please help me get turned and repositioned while in bed or in my wheelchair/chair; Call light accessible<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's policy titled Care Plans-Comprehensive states the following: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental, and psychological need is developed for each resident. 1. Our facility's care planning interdisciplinary team in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes but is not limited to the MDS. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associate with identified problems; c. Build on the resident's strengths; d. Reflect the residents expressed wishes regarding care and treatment goals; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsive for each element od care; g. Aid in the preventing or reducing declines in the residents functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing in a rehabilitative program and j. Reflect currently recognized standards of practice for problems areas and conditions. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956<br><br>Based on observation, interview, and record review, the facility failed to revise the care plan for one (R101) of six residents reviewed. Findings include:<br><br>Review of the facility record for R101 revealed an admitted [DATE] with diagnoses that included Heart Failure and Dementia. The record also indicated that R101 was legally blind and stated under Special Instructions that all personal items should be within reach.<br><br>On 08/06/24 at 10:38 AM, R101 was observed laying in bed. Their water cup was on the over-bed table next to the wall at the head of the bed, out of the residents reach.<br><br>On 08/07/24 at 11:51 AM, R101 was observed laying in bed. Their water cup was on the over-bed table next to the wall at the head of bed as it was the previous day. R101 was asked if they were able to reach their water cup if they wanted a drink and they stated No.<br><br>On 08/08/24 at 10:14 AM, R101 was observed laying in bed. Their water cup was on the over-bed table adjacent to the head of bed, out of the resident's reach.<br><br>Review of R101's care plan revealed no indication the resident should not have access to their water cup.<br><br>On 08/08/24 at 1:48 PM, the facility Director of Nursing (DON) reported their understanding was that R101's water cup was kept out of reach as the resident has difficulty managing the cup independently due to impaired coordination and vision impairment. The DON reported their expectation is that the availability or placement of the resident's water cup as well as ensuring the resident is offered assistance for drinks of water between meals should be specifically addressed in the resident's care plan.<br><br>Review of the facility policy Care Plans-Comprehensive revealed the entry Revisions: 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. |

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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** 50223<br><br>Based on observation, interview, and record review, the facility failed to administer PEG (Percutaneous Endoscopic Gastrostomy) tube feeding and medication via feeding tube per physician's orders or one (R482) out of one reviewed for PEG tube use. Findings include:<br><br>R482<br><br>On 08/07/24 at 2:26 PM, R482 was observed in their medical recliner chair. A tube feeding pump was observed in the room which was powered off. No tube feeding bottles or tube feeding were observed in the room.<br><br>On 8/7/24 at 4:15 PM, R482 was observed in their chair. Tube feeding is observed infusing at 65ml (milliliters) per hour through a pump. The pump was observed to show a remaining volume of 1220ml.<br><br>On 08/08/24 at 8:05 AM, R482 was observed lying in bed on their back. No tube feeding was observed infusing or in the room. The pump was observed next to the resident's bed powered off. There was no tube feeding bottle or tubing noted in the room.<br><br>A review of R482's record revealed they were admitted to the facility on [DATE] with diagnosis of cerebral infarction due to embolism of right cerebellar artery. A review of the minimum data set revealed a Brief interview for mental status score of 00 indicating cognitive impairment.<br><br>A review of R482's physician orders revealed the following order: Enteral feed every shift for nutrition and hydration Tube feeding: Jevity 1.5 @ 65ml/hr x 20hrs (up 2pm/down10am)or until dose complete = 1300ml/1950 calories via pump. Flush PEG tube with 65ml/hr water while TF (tube feeding) is infusing.<br><br>A review of R482s medication orders revealed an order for Levothyroxine to be administered at 5:00AM.<br><br>On 08/08/24 at 8:38 AM, during an interview, Licensed Practical Nurse (LPN) B confirmed R482 has tube feeding that is supposed to infuse from 2PM until 10 AM. LPN B was asked why R482's tube feeding was not currently infusing. LPN B stated let me check with the night nurse, (they) are still here and gestured to the nurses station.<br><br>On 08/08/24 at 8:40 AM, a concurrent interview was conducted with LPN E and Clinical Care Coordinator (CCC) C. LPN E stated, The order is for it to infuse for that time frame or until the volume is complete. LPN E was asked if they knew why it was taken down early. and comfirmed they were the one that took the tube feeding down. LPN E was asked what time they stopped the tube feeding. LPN E just a little bit ago like 8:15AM.<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 | LPN E was asked if nurses put in a progress note or anything when tube feeding is started stopped or flushed. CCC C explained that they do not put in a note and that they just follow what the physician order says. CCC C was asked if R482's tube feeding is being held before and after the administration of levothyroxine. CCC C stated it doesn't have to be held for that and explained that the pharmacy that the facility used to use told them that it did not have to be held.<br><br>On 08/08/24 at 9:12 AM, during an interview, Registered Dietician (RD) stated t R482 gets Jevity 1.5 at 65ml per hour and it should it be running for 20 hours. RD was told that R482's tube feeding was not started until sometime after 2:30PM and was already stopped sometime prior to 8:05AM. RD confirmed the resident would not be getting (their) caloric needs. R482 consumes nothing by mouth so we don't want to pause it for too long.<br><br>On 08/08/24 at 9:37 AM, during an interview, the DON explained that tube feeding should be held for residual amounts over 100 (ml) and the doctor should be notified and it should also be held if the resident needs to lay flat during care or changing. The DON stated, the orders say the dose and time to hang and take it down. if something happens in between that's abnormal they would put an order to hold it and they should let each other know and put in a nurses note. The DON was asked if tube feeding should be held before and after the administration of Levothyroxine. The DON stated pharmacy has not made that recommendation. The pharmacy told us that Levothyroxine only interacts with soy, dairy and caffeine.<br><br>On 08/08/24 at 10:02 AM, The DON was provided the manufacturers label for Jevity 1.5 which listed three soy containing ingredients and also included a warning that the product contains milk and soy. The DON stated, I will have to get with pharmacy about this.<br><br>A review of the manufacturer's recommendation for Levothyroxine states Take Synthroid with only water and on an empty stomach. Wait 30 minutes to 1 hour before eating or drinking anything other than water<br><br>A review of the facility's policy titled Enteral Nutritional Feeding states the following: Enteral Feeding Includes: PURPOSE: To provide liquid nourishment and adequate hydration through a tube, into the stomach. ENTERAL TUBE FEEDING: The physician order is to include the following: a. Formula b. Route c. Rate d. Gravity or pump e. Start and stop times f. Total amount of water intake to be consumed in 24 hours 1. The Dietician or Licensed Nurse will determine how water allowance is distributed, and this will be documented in the medical record 2. Checking Residual- a. Will be completed per physician order only b. Use a syringe to aspirate stomach secretions. c. If residual is present follow physician orders for replacement of feeding contents, holding of feeding, or disposal of content. d. If concerns with abdominal distention, pain, nausea, vomiting, of obstruction Notify physician for further orders 3. When pump is used follow manufactures directions for use. 4. Change and date enteral tubing with each new bottle of formula 5. Syringe is labeled and dated and replaced every 24 hours. 6. Closed tube feeding formula will hang no longer than 48 hours and open systems no longer than 8 hours unless otherwise specified by the manufacturer. 7. Administration of tube feeding and water flushes will be documented in the medical record Nursing .MONITORING THE RESIDENTS ON ENTERAL FEEDINGS: 1. Monitor resident's receiving tube feedings for complications which may include diarrhea, constipation, abdominal distention, nausea, vomiting, and aspiration 2. Notify the physician for any complications. 3. Head of bed must be elevated 30-45 degrees at all times during feeding and for at least 30 minutes after the feeding unless otherwise indicated per order/plan of care. |

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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** 50223<br><br>Based on observation, interview, and record review, the facility failed to secure on oxygen tank for one (R108) of one resident reviewed for oxygen therapy. Findings include:<br><br>R108<br><br>On 08/06/24 at 9:23 AM, 10:17 AM, 10:40 AM, and 12:20 PM, an unsecured portable oxygen tank was observed in R108's room.<br><br>On 08/07/24 at 8:17 AM, 10:34 AM, 11:55 AM, 2:17 PM, and 4:04 PM, R108 was observed in bed wearing oxygen per nasal canula via concentrator. An unsecured portable oxygen tank was observed in R108's room.<br><br>A review of R108's record revealed they were admitted to the facility on [DATE] with a diagnosis of acute on chronic congestive heart failure and acute on chronic respiratory failure, unspecified dementia. A review of the minimum data set (MDS) revealed a Brief interview for mental status (BIMS) score of 6 indicating cognitive impairment.<br><br>On 8/8/24 at 2:05 PM, during an interview, Clinical Care Coordinator (CCC) C was asked how portable oxygen tanks should be stored while in a resident's room. CCC C explained they can be in a metal wheeled holder or secured in a bag if it's on a wheelchair.<br><br>A facility policy on oxygen storage was requested and not returned by the completion of the survey. |

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| 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223<br><br>Based on observation, interview, and record review, the facility failed to safely secure medications for two (R6 and R29) of two residents reviewed for medication storage. Findings include:<br><br>R6<br><br>On 08/07/24 at 8:16 AM and 08/07/24 10:36 AM, R6 was observed sleeping in bed. Timolol eye drops were observed on R6's bedside table within reach of R6.<br><br>A review of R6's record reveals they were admitted to the facility on [DATE] with a diagnosis of heart failure, unspecified, and dementia. A review of R6's minimum data set (MDS) reveals a brief interview for mental status (BIMS) score of 6 indicating cognitive impairment.<br><br>A review of R6 physician orders revealed no order for medication self-administration.<br><br>R29<br><br>On 08/06/24 at 9:10 AM, 10:55 AM, 12:40 PM, and 2:23 PM, albuterol 90mcg (microgram) inhaler, artificial tears eye drops, and nasal spray medications were observed on R29's nightstand within R29's reach.<br><br>On 08/07/24 at 8:09 AM, the albuterol 90mcg inhaler, artificial tears eye drops, and nasal spray medications were observed on R29's nightstand still within R29's reach.<br><br>A review of R29's record revealed they were admitted to the facility on [DATE] with a diagnosis of periprosthetic fracture around internal prosthetic right hip joint. A review of R29's MDS revealed a BIMS score of 14 indicating cognitive impairment.<br><br>A review of R29's physician orders revealed no orders for medication self-administration.<br><br>On 08/07/24 at 10:45 AM, during an interview Clinical Care Coordinator (CCC) C was brought to the room of R6 and R29 and shown the medications at bedside. CCC C was asked if the medications are supposed to be kept at the bedside for the two residents. CCC C stated, As much as I'd love to say yes the answer is no. I'll take care of it.<br><br>A review of the facility's policy titled Medication Administration states: Residents can self-administer medications when specifically authorized by the attending physician in accordance with procedures for self-administration of medication. |

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|---|---|---|---|
| | 235547 | A. Building<br>B. Wing | 08/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakepointe Senior Care and Rehab Center, L L C | 37700 Harper Avenue<br>Clinton Township, MI 48036 |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220<br><br>Based on observation, interview and record review the facility failed to ensure call lights were maintained within reach for dependent residents for six residents (R117, R6, R118, R48, R482, and R108) of eight reviewed for call light placement. Findings include:<br><br>R117<br><br>A fall report dated 07/20/24 documented R117 had a fall from their bed. The reported indicated R117 rolled out of bed due to agitation.<br><br>On 08/06/24 at 1:26 PM, R117 was observed to be in bed. The call light for R117 was observed to be looped over the bracket of the tube feeding machine. The machine/pole was at the top edge of the bed and away from the side of the bed around two feet.<br><br>On 08/07/24 at 8:29 AM, R117 was observed to be in bed, on their left side, angled toward the door. The call light was on the floor around the base of the tube feed stand.<br><br>On 08/07/24 at 7:55 AM, 8:29 AM, and 9:16 AM, R117 was observed to be in bed. The call light was at foot of tube feed pole. At 10:54 AM and 1:43 PM, R117 was observed to be on their left side in bed. The call light was on the floor at the feet of the tube feed pole.<br><br>A review of the record for R117 revealed R117 was admitted into the facility on [DATE]. Diagnoses included Stroke, Malnutrition and Heart Attack. The Minimum Data Set (MDS) assessment dated [DATE] indicated severely impaired cognition and total dependence for all Activities of Daily Living, bed mobility and transfer. The care plan dated 02/27/27 documented .Please help me get turned while in bed or in my wheelchair .Bed Mobility 2 (person assist) PA .Call light accessible .I have cardiac issues .Anticipate needs if unable to communicate them myself .<br><br>On 08/08/24 at 8:57 AM, the clinical care coordinator/unit manager (CCC) O for R117 was asked about call light use by R117 and reported R117 had used it prior to the decline but currently did not use it much.<br><br>On 08/08/24 at 12:04 PM, call light position for residents was reviewed with the Director of Nursing (DON). The DON reported call lights should be in reach unless otherwise documented in the plan of care.<br><br>50223<br><br>R6<br><br>On 08/06/24 at 9:21 AM, R9 was observed sitting on the side of their bed. R9's call light was observed hanging on the wall behind their bed out of reach. R9 was asked do you have a call light? R9 stated No. All I have to do is yell.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 08/07/24 at 10:36 AM, R9 was observed sleeping in bed. R9's call light was observed on the floor under their bed out of reach.<br><br>On 08/07/24 at 1:06 PM, 2:17 PM, and 4:07 PM, R9's call light was observed to still be on the floor under their bed out of reach.<br><br>On 08/08/24 at 1:08 PM, R9 was observed sitting in their recliner. R9's call light was observed on their bed across the room out of reach.<br><br>A review of R6's record reveals that they were admitted to the facility on [DATE] with a diagnosis of heart failure, unspecified, and dementia. A review of R6's minimum data set (MDS) reveals a brief interview for mental status (BIMS) score of 6 indicating cognitive impairment.<br><br>R48<br><br>On 08/06/24 at 8:53 AM, R48 was observed lying in bed. R48's call light was observed hanging on the wall above the head of their bed out of reach. R48 was asked, do you have a call light. R48 stated, no.<br><br>On 08/06/24 at 10:20 AM, 12:06 PM, and 2:39 PM, R48 was observed sitting up in a medical recliner in their room. R48's call light was observed on the floor, under their bed across the room out of reach.<br><br>On 8/8/24 at 1:05PM, R48 was observed sitting up in their chair. R48's call light was observed hanging on the wall above the head of their bed across the room out of reach.<br><br>A review of R48's record revealed that they were admitted to the facility on [DATE] with a diagnosis of neurocognitive disorder with lewy bodies and unspecified dementia. A review of the MDS revealed a BIMS score of 11 indicating cognitive impairment.<br><br>R108<br><br>On 08/06/24 at 9:23 AM, 10:17 AM , 12:20 PM, 08/06/24 at 12:21 PM, and 2:26 PM, R108 was observed in bed with head elevated. R108's call light was observed hanging on wall above head of bed out of reach.<br><br>On 08/07/24 at 8:17 AM, 10:34 AM, and 1:06 PM, 2:17 PM, and 4:04 PM, R108 was observed in bed with head elevated. R108's call light was observed hanging on wall above head of bed out of reach.<br><br>08/08/24 at 8:01 AM, 8:30 AM, R108 was observed in bed. R108's call light was observed out of the residents reach.<br><br>On 08/08/24 at 08:47 AM, during an interview certified nurse assistant CNA A was asked if R108 was supposed to have a call light. CNA A stated, yes. CNA A was observed to look at R108's call light hanging on the wall and then placed it on R108's bed within their reach.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of R108's record revealed they were admitted to the facility on [DATE] with a diagnosis of acute on chronic congestive heart failure and acute on chronic respiratory failure, unspecified dementia. A review of the MDS revealed a BIMS score of 6 indicating cognitive impairment.<br><br>R118<br><br>On 08/06/24 at 10:41 AM, R118 was observed in bed. R118 stated, can I get some pain medication? R118 was asked if they had their call light. R118 responded, No. R118's call light was observed to be on the floor under their bed out of reach.<br><br>On 08/06/24 at 12:23 PM, R118 was observed to be yelling I need a pain pill! R118's call light was observed to be on the floor behind the back of their bed out of reach.<br><br>On 08/08/24 at 1:09 PM, R118 was observed in bed and their call light was observed to still be out of reach as previously described. R118 was asked if they had their call light. R118 stated no. R118 was asked, what happens if you need help? R118 responded, I yell.<br><br>A review of R118's record revealed they were admitted to the facility on [DATE] for a diagnosis of delusional disorders and other chronic pain. A review of the MDS revealed a BIMS score of 12 indicating cognitive impairment.<br><br>R482<br><br>08/06/24 at 10:08 AM, R482 was observed in bed. R482's call light was observed on the floor next to their bed out of reach.<br><br>On 08/07/24 at 10:38 AM, 11:57 AM, and 01:08 PM, R482 was observed sitting up in their chair. R482's call light was observed on their bed by the pillow not in reach.<br><br>A review of R482's record revealed they were admitted to the facility on [DATE] with diagnosis of cerebral infarction due to embolism of right cerebellar artery. A review of the MDS revealed a BIMS score of 00 indicating cognitive impairment.<br><br>On 08/08/24 at 9:06 AM, during an interview, Licensed Practical Nurse (LPN) B explained the policy is call lights are within reach and if someone can't use a regular call light they use a different type that can go under their pillow.<br><br>On 08/08/24 at 9:37 AM, during an interview, the Director of Nursing (DON) explained it was their expectation everyone should have a call light in reach and that if a resident prefers it in a certain place like on their bed side table, they try to follow their preferences.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy titled Call Light Policy states: POLICY: Call lights will receive consistent and adequate response in order to best meet the individual needs of each resident. PROCEDURE: 1. Call lights will be placed within reach of the resident 2. Call light activation will be identified by a light above the resident doorway and an audible alarm at/near each nursing station or a paging system with monitors. 3. Call lights will remain on until staff is available to meet the resident needs/requests. 4. Call light responses will be prioritized based on need, not necessarily in order received. 5. Priority responses may include but are not limited to: falls, injury, and medical emergency 6. Each staff member is responsible to respond to call lights and provide assistance as their level of training allows. 7. Call light response time may vary dependent on time of day, individual resident need, and the number of call light requests at any given time. 8. Concerns related to call light response time will be documented utilizing the Concern/Grievance procedure and followed up through QAPI and/or resident council. |