STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, interview and record review, the facility failed to maintain the dignity of 9 residents (Resident #4, 5, 19, 28 and 45 and 4 out of 13 from the confidential group interview), out of 25 residents reviewed for dignity, from a total sample of 28 residents, resulting in feelings of shame, embarrassment and decreased self-worth. Findings include: Resident #5 According to the electronic medical record, Resident #5 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. According to a Minimum Data Set (MDS) quarterly assessment dated [DATE], Resident #5's staff assessment score for cognition was a 2 indicating Resident #5 had moderately impaired cognition. Resident #5 was not able to speak English well enough to answer this surveyors questions. During an observation on 02/05/18 at 01:39 PM, Resident #5 was observed in bed, on back. Her eyes were closed. Respirations were easy. The call light was observed to be hanging on headboard (right). The call light was not in reach of Resident #5. During an observation on 02/06/18 at 09:42 AM, it was observed that a clergy member was in to see resident. Clergy Q is a friend and visits daily. Resident #5 was observed to be in a wheelchair and the call light was again observed to be hanging on the head board of her bed and not in reach. During an interview on 02/06/18 09:47 AM with Clergy Q, they stated when Resident #5 is in her wheelchair she doesn't have call light in reach. Clergy Q stated they alerted staff of needs. Clergy Q stated when staff doesn't come to assist Clergy Q has told Resident #5 to pee in diaper or have a bowel movement which Clergy Q stated Resident #5 does not like to do. Resident #19 According to the electronic medical record, Resident #19 is a [AGE] year old female admitted to the facility on [DATE] with the Diagnoses: [REDACTED]. According to a quarterly MDS assessment dated [DATE], Resident #19 had a brief interview for mental status score (BIMS) of 8 out of 15 indicating moderate cognitive impairment but able to complete an interview. On 02/05/18 at 01:37 PM, an observation was made of Resident #19 in bed on her right side. The call light (metal press pad) was observed to be hanging on the bed's headboard, not in reach of resident. On 02/06/18 at 09:57 AM during an observation and interview with Resident #19, Resident #19 observed in wheelchair to right of her bed. She was dressed, her shoes were on. Resident #19 was observed to have a half tray to the left side armrest of her wheelchair. During this observation, a metal pressure call light was observed hanging on left side of headboard of Resident #19's bed. When asked, Resident #19 confirmed that the call bell is often out of her reach. When asked how she can seek assistance Resident #19 stated, I call out if I hear someone coming . IF I wake up. Resident #28 According to a facility face sheet dated 2/12/18 at 2:46 PM, Resident #28 was a [AGE] year old male admitted to the facility on [DATE] with the Diagnoses: [REDACTED]. Review of a Minimum Data Set quarterly assessment dated [DATE] for Resident #28 reflected a BIMS score (brief interview for mental status) of 12 out of 15 indicating he was cognitively intact. On 02/05/18 at 01:47 PM, Resident #28 was observed in bed. He was unshaven. Resident #28 stated was in (Name of) hotel but had a stroke. He stated, I can't go back. Resident #28 stated had a shower today but no one shaved him. Resident #28 confirmed he liked to be shaved. During an observation on 02/07/18at 01:03 PM, Resident #28 was observed propelling self in his wheelchair with right foot and right hand, left foot was up on a foot rest. Resident #28 face was shaven. During an observation on 02/12/18 at 09:20 AM, Resident #28 was observed in bed, awake. Resident #28 was unshaven. During an observation and interview on 02/12/18 at 02:19 PM with Resident #28, he was observed in bed. Awake. This surveyor mentioned his face wasn't shaved. Resident #28 shook his head no. When asked if he wanted to be shaved, he shook his head no. Confidential Resident Council Interview On 02/06/18 at 02:31 PM, a Resident Council interview of 13 Residents and 1 family member revealed, one resident stated, aides are called to assist to toilet and leave without fulfilling their needs and took an hour to come back. You're going to have to wait. One resident had been told. Four out of 13 residents agree this occurs. Four of the 13 residents have had accidents (soiling or wetting themselves) because of the time it took waiting for assistance. One resident stated aides are upset when they turn the light back on. The residents stated they felt, dirty, horrible, not respected and angry. One resident stated they put on the call light and waited 2 hours. When asked how they know it was 2 hours, they stated there is a clock next to them and they watched the time. According to a facility policy titled, Call Lights dated 12/2009 reflected, Purpose: To use a light and/or sound system to alert staff to patient needs .Answer all call lights in a prompt, calm and courteous manner. All staff regardless of assignment can answer call lights .Turn of call light - light should not be turned off until request is met. Respond to request or, if unable to do so, refer request to appropriate staff member immediately. Always position call light conveniently for use and in reach. Resident #4 Review of the facility Face Sheet, dated 2/7/18, and the annual Minimum Data Set assessment (MDS) (an assessment to identify resident care needs), dated 1/17/18, reflected that Resident #4 was an [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected that she had a Brief Interview for Mental Status assessment (BIMS) (a cognitive screening tool) of 13 out of 15, which indicated she was cognitively intact. She required one person extensive assist for bed mobility, dressing, eating, toilet use, personal hygiene and bathing. During an interview on 2/6/18 at 10:11 AM, Resident #4 stated that some of the Certified Nursing Assistant's (CNA) did not talk to her or tell her what they are doing with care. During an observation and interview on 2/6/18 at 10:29 AM, Resident #4 reported that she had difficulty brushing her teeth due to hand tremors and both hands not working well at times. She reported that facility staff did not always brush her teeth and that at times, she would go for weeks without having her teeth brushed. She also reported that staff helped her brush her teeth about once every two months. Plaque and debris were observed on her upper and lower front teeth. The resident reported that she was unsure if the staff were aware that she had difficulty brushing her teeth. In an interview on 2/7/18 at 3:04 PM, CNA FF reported that the resident knew she could do certain things but she wanted them done for her. CNA FF stated that Resident #4 could brush her own teeth if the toothbrush was put in her hands. If the resident stated she had a hard time brushing her teeth, CNA FF brushed them for her.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) On 2/8/17 at 11:09 AM, CNA T was observed giving Resident #4 a shower. A toothbrush and toothpaste were in the shower room. At the end of the shower, CNA T was preparing to take Resident #4 back to her room to be put to bed, per resident request. CNA T reported that Resident #4 usually brushed her teeth on her own in her bathroom. The resident stated she was unable to independently brush her teeth and had not had them brushed yet that day. CNA T inquired about the reason, and the resident reported it was due to her hand tremors. After returning to the resident's room, CNA T brushed Resident #4's teeth. During an interview on 2/8/18 at 1:55 PM, Resident #4 reported that it felt nice to have her teeth brushed that day. She stated that she brushed her teeth twice daily at home but has never had them brushed twice a day while at the facility. She reported that at times she didn't get them brushed even once a day and may have gone for months without having her teeth brushed. The resident stated, It doesn't make me feel very good. Resident #45 Review of Resident #45's Face Sheet dated 2/8/18, revealed he was an [AGE] year old male admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. During an interview on 02/05/18 at 09:57 a.m., Resident #45 complained of slow call light response but could not recall times or what needs were not being met, just general frustration with delays in care. On 2/6/18 at 8:41 a.m., Resident #45 was observed sitting on the edge of his bed in his room eating breakfast and put his call light on. Resident #45 placed his call light on 2 more times before he received the hot water at 9:15 a.m.
F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on interview and record review, the facility failed to address Resident Council grievances according to 12 of 13 of the Confidential Resident Interviews, from a total facility census of 67 residents, resulting in unresolved resident concerns, unmet care needs and decreased feelings of self-worth. Findings include: Review of Resident Council Minutes dated 1/29/18 reflected Concerns were noted in nursing, dietary, Maintenance/Housekeeping/Laundry. Further details of the concerns were not noted on the form. A request for concern forms related to the concerns indicated was made to the Activity Director. The section of the Resident Council Minutes addressing Old Business reflected resolution of previous month's concerns was NOT satisfactory. Review of Resident Council Minutes dated 12/27/17 reflected concerns were noted in the area of nursing, dietary, maintenance/housekeeping/laundry. Review of Resident Council Minutes dated 11/27/17 reflected concerns were noted in nursing, and dietary. Review of Resident Council Minutes dated 10/30/17 reflected concerns were noted with nursing, dietary, maintenance/housekeeping/laundry. Review of Resident Council Minutes dated 9/26/17 reflected concerns were noted with nursing, dietary, and maintenance/housekeeping/laundry. Review of Resident Council Minutes dated 8/28/17 reflected concerns were noted with nursing, dietary, and maintenance/housekeeping/laundry. On 02/06/18 at 02:31 PM during a Confidential Group Meeting with 13 Residents present and 1 family member: -One of 13 residents said the facility staff take grievances and get back with the Council with a resolution. The rest of the residents disagreed. -Certified Nurse's Aides (CNA) are called because of the need to toilet and the CNA's left without fulfilling their need and took an hour to come back. You're going to have to wait. One had been told. 4 Residents agree this occurs. 4 residents have had accidents. -CNA's are upset when they turn the light back on. Residents replied the feel, dirty horrible, not respected, angry when being made to wait to toilet and soiling or wetting themselves. One Resident said they waited 2 hours. They stated they had a clock next to them and watched the time. -Residents stated CNA's knock on room doors and identify self but some don't knock on bathroom doors. This has been a complaint in resident council they said. Review of facility documents titled, Concern Form reflected the following: 11/27/17 Resident Council concern, Nursing staff is too loud at night between 2:00 AM and 3:00 AM on (name of hall), end of building. At the bottoms of the form under Resolution of Concern, yes is checked. Administrator came into building on 12/1/17 at 2:45 AM. Building was quiet. Met with staff to relay the concerns. Will continue to make visits. There is no documentation of how the Resident council was informed of this or if they were satisfied with the resolution. There is a signature and it is dated 12/1/17. 12/12/17 Resident Council concern, (name of hall) 3rd shift talking too long to answer call light. At the bottom of this form is Resolution of Concern and a check box for yes or no and if no to explain, how the complainant was notified of the resolution and if complainant was satisfied. This area has not been completed as of 2/6/18. The form was completed by a registered nurse (RN) and dated 1/17/18 in the area of resolution as being resolved. 12/27/17 Resident Council concern, Would like a new room because roommate's visitors stay late and feels she has no privacy. Follow up was done by social services. After speaking with resident she would like to go to bed around 8:00 PM. Requested family that if they want to stay after 8:00 PM to try and meet in one of the lounges. Resident continue to request a room change on 1/3/18. Call placed to guardian to discuss options on 1/3/18. Spoke with guardian and explained residents request. She doesn't want resident moved and says she is just complaining to get a private room and she wants resident to stay in current room . The box yes is checked for complainant satisfied with resolution (meaning the guardian) dated 1/4/18. 12/27/18 Resident Council concern, Floors need to be deep cleaned again. Nail polish spill in town room. There is no documentation of how the Resident Council was notified of resolution deep cleaning the floor but this is signed as resolved on 1/8/18. 12/27/18 Resident Council concern, meal tickets not read correctly. Wrong items on trays. The resolution of concern was, On 1/11/18 (name of 3 residents) stated correct meal items on tray. There was no documentation on how the Resident Council was notified of the resolution or if they were satisfied. Signed as resolved on 1/4/18. 1/29/18 Resident Council concern, Aides always seem to be in a hurry not asking resident if they need anything else before they leave the room. Documentation of facility follow up reflected, This nurse spoke with (name of 3 staff members) about concerns. CNA's educated. Information added to nursing meeting on 7th and the 9th as well. The nurse signed in the Resolution of concern that one on one notification was done on 2/2/18 and signed as resolved on 2/2/18. There is no documentation that the Resident Council was notified of facility follow up and no documentation that their concerns have been resolved. 1/29/18 Resident Council concern, Resident stated noise levels on 3rd shift have improved since last resident council but call light response times have not improved. There is no documentation about facility follow up or Resolution of the concern. 1/29/18 Resident Council concern, Resident state they are not getting fresh water passed to their room and have to ask for water. Resolution of concern noted was This nurse spoke with said residents, water cups full of ice and water at time of convo (conversation). Continued periodic checks to assure ice water at bedside. This was dated as being resolved on 2/2/18 but there is no documentation that the complainant is satisfied with the resolution. 1/29/18 Resident Council concern, Meatloaf was very hard, not good the other night. The resolution box NO was checked. Resolution documented, Meatloaf is not on current week menu. Will follow up on when meatloaf is served again. Meatloaf will be on the menu 2/17/18. There is no documentation when the Resident Council was notified of the facility follow up or if they were satisfied with the resolution. This form is signed as being resolved on 2/2/18 1/29/18 Resident Council concern, Housekeeping not cleaning under the resident's bed or dusting well enough. Not moving things around to dust. Resolution of concern was documented as, more attention to and more frequency to under beds and moving furniture. There was no documentation when the Resident Council was notified or if they were satisfied with the resolution. This was signed by a Housekeeper on 1/31/18 as being resolved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2)
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** Based on interview and record review, the facility failed to ensure that a legal guardian was in place for 1 resident (Resident #33) of 28 residents reviewed for advance directives, from a total sample of 28 residents, resulting in an incompetent resident not having a guardian in place and medical decisions being made by an inactivated guardian. Findings include: Review of the facility Face Sheet, dated [DATE], reflected that Resident #33 was an [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the medical record reflected a document titled, (State) Probate Court (County) Letters of Guardianship of Individual with Developmental Disability. The document reflected, The order appointing you as guardian expires on [DATE] .These letters of guardianship expire on [DATE] . The document reflected that the expiration date had been extended to [DATE]. A progress note by Social Worker (SW) W on [DATE] reflected that a request was sent to the facility attorney for guardianship due to expire on [DATE]. A progress note by SW W on [DATE] reflected that the attorney was going to contact the guardian to find out why the annual report was not submitted. The note reflected that if the guardian did not get in touch with them, the attorney would file for a public guardian. Review of the medical record reflected a progress note by SW W on [DATE] that SW W had confirmed with the probate court that the Letters of Guardianship were processed on [DATE] and guardianship was extended until [DATE]. In an interview on [DATE] at 2:37 PM, SW W reported that the court would not send confirmation papers to the facility and that the guardian had to provide them. In an interview on [DATE] at 1:01 PM, SW W reported that she scheduled review of advance directives for audits quarterly and reviewed them at care conferences. She reported that Resident #33 had a guardian in place and was a full code (wanted life-saving measures). During an interview on [DATE] at 2:37 PM, SW W reported that probate court was contacted [DATE] (after the survey team inquired about guardianship), and they stated guardianship expired on [DATE]. SW W stated the guardian listed had continued to attend care conferences, act as guardian and make decisions. SW W reported that the guardian had attended the care conference in [DATE]. At that time, the guardian stated she would be getting papers soon from the court because she had submitted everything to renew guardianship. SW W stated, What scares me is that she is making decisions when she is not a legal guardian. SW W stated that during her conversation with the probate court, the supervisor said she did not see how that fell through the cracks. According to SW W the court said that when guardianship expired, (Agency name) or (Agency Name) should have been triggered to put a new guardian in place. A progress note by SW W on [DATE] at 11:22 AM reflected that the facility attorney's office had initiated the process to petition for a new public legal guardian for Resident #33.
F 0580 **Level of harm** - Actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Durable Power of Attorney (DPOA) and physician of a change in condition for 1 resident (Resident #42) and failed to promptly notify the DPOA of a change in condition for 1 resident (Resident #13) of 2 reviewed for notification of change, from a total sample of 28, resulting in absence of treatment and delay of treatment. Findings include: Resident #42 Review of the medical record reflected that Resident #42 was a [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the medical record and advance directive reflected that Resident #42 was a full code, which indicated that her wishes were for life-saving measures. Record review of a progress note dated [DATE] at 10:00 AM reflected, called into room by cena (competency evaluated nurse aide) at 7:40 am, resident noted with no resp.(respirations) or pulse, code blue called and CPR was initiated, 911, (Physician Group), family and manager on call all contacted, (ambulance company), fire and police arrived, code continued until 8:06am when it was stopped and time of death was pronounced after (paramedics) contacted hospital and order was made to stop CPR, family, (Physician group), manager notified of death, police in contact with M.E. (medical examiner) and ok to release body to funeral home, daughter here at 9:15am, awaiting funeral home staff for release of body. Record review of a progress note by Physician's Assistant (PA) VV on [DATE] at 11:21 PM reflected that the resident was seen for [MEDICAL CONDITION]. The note reflected that her Brain Natriuretic Peptide (BNP) was over 3,000 (BNP is a laboratory test that measures levels of a protein made by the heart and blood vessels. The reference range for the result is less than or equal to 99). The note also reflected that her Creatinine was 3.4 (Creatinine is a laboratory test that measures a waste product from the normal breakdown of muscle tissue that is filtered through the kidneys. The reference range for the result is 0.600 to 1.200). Documentation reflected that the resident was more confused than her baseline and that a care conference would need to be set up with the daughter to discuss options, including hospice versus renal consult and [MEDICAL TREATMENT]. A progress note documented by Social Worker (SW) W on [DATE] at 12:05 PM, reflected that the PA requested to speak with the DPOA (durable power of attorney) regarding the plan of care and medical status. A teleconference was set up with DPOA UU for [DATE]. During a phone interview on [DATE] at 2:13 PM, DPOA UU reported that she had not been notified of changes of changes in condition at all times. She reported that the SW had called her (on [DATE]) to say that someone wanted to talk to her about the resident's [MEDICAL CONDITION]. DPOA UU acknowledged that someone was going to call her back on [DATE] because the timing was not good that day. She reported she had not been notified that the resident's condition was declining and that nobody had suggested to send the resident to the hospital. DPOA UU reported that she would have wanted the resident sent to the hospital for evaluation and treatment if she had known of changes in condition. She stated, I have always sent her to the hospital. She re-stated that SW had stated they wanted to talk about changes. Referring to [DATE], DPOA UU reported, They called me at 8:00 AM to let me know there was a change in condition. They called me at 8:14 AM to let me know that my mom was dead. Record review of laboratory testing reflected that a Comprehensive Metabolic Panel (CMP) was drawn on [DATE] at 12:20 PM. Creatinine was 2.454 and the carbon [MEDICATION NAME] level was 22.0 (the reference range was 21.0 to 31.0). On [DATE] at 6:30 AM, a CMP was drawn and reflected a creatinine of 3.140 and a carbon [MEDICATION NAME] of 16.0. A BNP test on [DATE] at 6:30 AM reflected a result of 1,715.0. A CMP was drawn on [DATE] at 6:50 AM. The creatinine level was 3.694 and carbon [MEDICATION NAME] was 16.0. The BNP result was 3,594.3. The lab report reflected a handwritten note by PA VV that a care conference with the family was needed. During an interview on [DATE] at 3:14 PM, Medical Doctor (MD) V reported that an elevated BNP was considered a change in condition. During a phone interview on [DATE] at 4:20 PM, PA VV reported that in the few weeks prior to her passing away, Resident #42 had been declining and overall was not doing well. PA VV reported that she completed her documentation from home and had not seen the patient at the actual time her progress note for [DATE] was documented. She reported she wanted to set up a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0580 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) conference with the daughter to discuss hospice. PA VV reported she spoke to the SW about setting up a care conference with the daughter (DPOA), and she passed away over the weekend, before the care conference. PA VV stated, I was moving towards making this patient comfortable. She was declining. When asked if an elevated BNP would have necessitated a call to the DPOA, PA VV reported, Yes, that is what I did. Documentation in the medical record reflected that SW W, who was not qualified to discuss laboratory results or medical conditions, made a phone call to the daughter. During a phone interview on [DATE] at 9:18 AM, Licensed Practical Nurse (LPN) X reported that earlier in the week of Resident #42's death, if she was having difficulty breathing, oxygen was put on her. She reported that on [DATE], she received report that the resident had some respiratory problems and to monitor her oxygen saturation levels. During a phone interview with (NAME)tered Nurse (RN) OO on [DATE] at 9:39 AM, she reported that she received report from LPN WW on the morning of [DATE] that the resident had pursed lip breathing during the night and that maybe she was short of breath. She was also told that oxygen was applied during the night, which gave her a little relief. During a phone interview on [DATE] at 10:23 AM, LPN WW reported that she worked with Resident #42 overnight on [DATE] and into the morning of [DATE]. She reported that the resident did pursed lip breathing sometimes. LPN WW stated that Resident #42 began pursed lip breathing on her shift. She applied oxygen and told the Certified Nursing Assistant's (CNA) to keep an eye on her and tell her if there was anything different. She reported that the oxygen saturation was at 96% that night, so she was not personally worried about the resident. LPN WW reported the resident seemed more comfortable, and the pursed lip breathing had resolved. She reported that she had not contacted the DPOA during her shift that night and stated, I assumed that was already done. LPN WW reported she did not personally report a change in condition to the doctor because she did not feel pursed lip breathing was a change for the resident. LPN WW stated she had first noticed pursed lip breathing that Thursday ([DATE]). Review of the medical record did not include documentation that the resident had pursed lip breathing for the time surrounding [DATE]. During an interview on [DATE] at 12:47 PM, MD V reported that he would have expected to be notified during the night about pursed lip breathing if he was on call. He stated, Honestly they should have sent her out .If someone has pursed lip breathing, they need to be sent out (to the hospital). MD V reported that the conversation with the survey team was the first time he had been notified that the resident had pursed lip breathing. Review of the facility policy titled, CHANGE IN CONDITION with a date of ,[DATE], reflected the purpose was to provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications. The policy also reflected, .immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed . Resident #13 A review of Resident #13's admission record dated [DATE], revealed Resident #13 was a [AGE] year old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. During an interview on [DATE] at 10:29 AM, Resident #13 stated she had a fall that morning. A laceration was observed above left eye, and a bruise on left knee. Resident #13 was observed to be in significant amount of pain. (NAME)tered Nurse (RN) P entered the resident's room at this time and stated that Resident #13 also had pain and range of motion issue on left hip. Resident #13 stated she fell because no one came to answer her call light and she had to go to the bathroom. RN P stated that she observed that the resident's wheel chair was behind her when she fell around 7:15 AM. on [DATE]. RN P stated that the call light was not on. When asked if Resident #13 had any fractures, RN P stated they are waiting for an x-ray. During an interview on [DATE] at 11:25 AM, Resident #13's Durable Power of Attorney (DPOA) ZZ stated she was just notified approximately 30 minutes ago (about 11 am) that the resident had a fall at 7 AM that morning. DPOA ZZ stated if she had known that Resident #13 had fallen she would have come to the facility hours ago. DPOA ZZ stated they notified her brother when he came to visit about 8 AM but he was not the DPOA. DPOA ZZ was also upset because they were just now doing an x-ray. On [DATE] at 12:36 PM, Paramedics were observed outside the door of Resident #13's room. When questioned as to what was happening, RN P reported they are transferring Resident #13 to the hospital because she was calling out in pain. RN P revealed that Resident #13's hip x-ray came back negative. RN P revealed she was going to be checked out and have a CT scan done. DPOA ZZ came out and stated that she had requested the resident be sent out. During an interview on [DATE] at 02:45 PM, Nursing Home Administrator (NHA) A was asked when a DPOA should be notified of a fall. NHA A stated that the DPOA should have been notified of the fall right away. On [DATE] at 03:30 PM, NHA A reported that RN P told the son about the fall when he came in at 8 o'clock. NHA A stated RN P did not call the DPOA until about 10:15 AM because RN P stated she was waiting for the doctor. NHA A stated it was an issue that the DPOA had not been notified and they were aware of it. Review of Resident #13's After Visit Summary (a report of Resident #13's hospital visit) on [DATE] reflected the following Diagnoses: [REDACTED]. -Closed fracture of left inferior pubic ramus, initial encounter (HCC) -Nondisplaced zone i fracture of sacrum, initial encounter for closed fracture (HCC) A review of the progress notes from [DATE] to [DATE] reflected the following information: -On [DATE] at 07:15, res (resident) observed on floor at foot of bed in front of w/c (wheelchair) with back against wall. laceration above left eye noted measuring 2.5 cm. Res assisted to bed via mechanical lift. c/o pain in left hip and head. ROM (ange of motion) performed WNL (within normal limits); able to flex/extend BLE (bilateral lower extremities). Scheduled [MEDICATION NAME] (a narcotic) given for pain. Bruise noted to left knee; denies pain in knee. laceration above eye cleansed with NS (normal saline). Approximated edges. Steri-strips applied. Wound continued to bleed. placed Band-Aid over steri-strips. -On [DATE] at 08:40, Note by Director of Nursing (DON) B, Approached by nurse (RN P's name). who stated resident was found on the floor by her bed, and assisted back to bed. Stated residents vitals were stable, neuro's initiated without current concern, full range of motion noted w/o pain at this time, although bruising noted to hip area. Nurse (RN P's name) noted laceration above eye, site cleaned and SS (steri-strips) and Band-Aid in place, bleeding did subside. Instructed nurse to order x-ray to hip, and inform of change in condition from current status. -On [DATE] at 09:47 Note by RN P, (Physician Group) ordered stata AP/Lat (anterior, posterior and lateral) Left hip X-ray. Awaiting (mobile x-ray company). -On [DATE] at 10:15, Note by DON B, Informed by Clinical Coordinator (name of (NAME)tered Nurse (RN) CC) , resident had increased pain during hygiene care. Mobile x-ray completed, PA (Physician's Assistant)assessed resident and awaiting x-ray interpretation, instructed CC (RN CC) resident would need to be transferred out for evaluation, CC (RN CC) stated she would speak to physician for transfer to ER. -On [DATE] at 11:25, Note by RN P, Res in severe pain. Radiology reveals no fracture of dislocation. Laceration to left eye continues to swell despite putting ice to area. MD assess res at bedside. MD recommends ER visit for eval. - On [DATE] at 22:42, Returned from ER accompanied by daughter, closed pelvic fx r/t fall. Bruising around left eye. new order for [MEDICATION NAME] 15 mg PRN and 10 mg PRN (as needed). Neuros within normal limits. -On [DATE] at 17:39, Resident is alert and orientated x2 with some confusion noted. c/o pain and gave PRN effective. continues neuro check for fall. some small amounts of swallowing difficulty noted-reported findings, therapy to eval [DATE]. resting in room, call light in reach. -On [DATE] at 09:41, SLP downgraded residents diet texture from regular to mechanical soft texture. Continue to monitor meal intakes. Follow up as needed. During an interview on [DATE], DPOA ZZ revealed that since the fall with fracture Resident #13 is on bed rest, is on oxygen (previously not on), and the diet has been downgraded from a regular diet to mechanical soft.
F 0604 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0604 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) Based on observation, interview and record review, the facility failed to keep one resident free from restraints and maintain physical function for one resident (Resident #57), out of 1 resident reviewed for restraints, from a total sample of 28 Residents, resulting in the restraint and physical decline of Resident #57 and the potential for psychological harm. Findings include: Review of Resident #57's Face Sheet dated 2/6/18, revealed Resident #57 was a [AGE] year old male admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. Resident #57 was not his own responsible party. On 02/05/18 at 11:06 a.m., Resident #57 was observed up in a geriatric style chair (reclined chair with foot rest) in hall. Resident #57 was asked if chair was comfortable and he said no. Resident #57 could not say how long he was up or why he was uncomfortable. Resident #57 said he wanted to go to bed. Certified Nurse's Aide (CNA) O was asked if Resident #57 needed to go to bed because he was uncomfortable and CNA O said, no, if he goes to bed he will stand up, walk and fall. CNA O readjusted the Geri chair to a more reclined position. On 02/08/17 at 9:20 am., CNA O and CNA RR put Resident #57 in bed from his geriatric style chair. CNA's O and RR provided hygiene care. CNA's O and RR said Resident #57 could not stay in bed because he would get up and fall. Resident #57 was placed back in his Geri Chair, in a reclined position in the hall after care. During an interview with the Minimum Data Set (MDS) (NAME)tered Nurse (RN) QQ on 2/12/18 at 9:50 a.m., RN QQ said Resident #57 received his geriatric style chair from hospice in July 2017 and she completed a significant change assessment at that time. RN QQ was asked why the geriatric chair was not coded as a restraint at that time and QQ responded she did not think of it. Review of Resident #57's Physical Therapy Discharge Note dated 6/8/17 (prior to receiving the geri-chair) reflected Resident #57 could walk 170 feet with a 2 wheeled walker and minimal assist of one person. During an interview on 2/12/18 at 2:00 PM, Therapy Director SS confirmed Resident #57 could walk 170 feet with a 2 wheeled walker and one person assist when Physical Therapy discharged him on 6/8/17. SS could not find the standard documentation that provided nursing with instructions to help maintain a Residents function when discharged from therapy. SS could not locate any documentation that would explain why nursing did not receive any instructions to continue to walk with Resident #57 when discharged from therapy on 6/8/17. Review of Resident #57's Physical Restraint assessment dated [DATE] and signed by RN CC documented the brand name of the geriatric chair is for positioning, it is not a restraint. During an interview with RN CC on 2/12/18 at 2:00 PM, Resident #57's Restraint Assessment completed by CC was reviewed along with fall incident reports that documented the intervention on 2 occasions to prevent falls was to recline Resident #57 in his geriatric wheelchair. RN CC said she was not aware Resident #57 was able to get out of a wheelchair or geriatric chair and when it was reclined he could not get out. CC said that was why she assessed the chair as a positioning device on 7/7/18 and the geriatric chair was not assessed again. CC said she was not aware Resident #57 was able to walk with one person assist in June and did not know why Resident #57's functional status was not maintained after he was discharged from Physical Therapy. Review of Resident #57's Incident Report dated 8/28/17 at 12:30 PM, reflected Resident attempted to get out of his recliner then staff assisted him to the floor as resident was sliding off the recliner. Did not hit head to the floor. Under corrective action documented, Staff will have name of geriatric style chair tilted back whenever resident is in name of geriatric style chair unless resident is eating or drinking (This made the geriatric style chair a restraint as evidenced by documentation that Resident #57 could get out of the chair when sitting up and stand when it was not reclined, no order for this restraint or restraint evaluation was located at this time). Review of Resident #57's Incident Report dated 12/1/17 at 7:01 PM, revealed Res (resident) at nurse's station in name of geriatric style wheel chair. Observed attempting to stand from chair, Resident's knee buckled and ended up on both knees on floor with feet in chair. Under corrective action documented, Must remain reclined between meals. (Restraining resident #57 to prevent falls, without an evaluation, orders or release times). Review of the facility Restraints policy dated 5/17, documented under procedures. 1. Prior to utilization of any restraint, the interdisciplinary group completes an evaluation of the patient including a review of hospital discharge records, transfer reports of other documents; an interview with the patient, family or patient representative about the patient's history and risk factors, previous interventions utilized and any medical evaluation of the presenting medical symptom necessitating the use of the restraint. (This information was not located, the restraint evaluation was not completed by the interdisciplinary group. The evaluation was completed by one person. The geriatric style chair was determined not to be a restraint by that one person not the group. None of the other steps in the facility policy were followed).
F 0636 **Level of harm** - Actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to complete an accurate restraint assessment for one resident (Resident #57), of 1 Resident Reviewed for restraints, from a total sample of 28 Residents, resulting in Resident #57 being physically restrained and declining in physical function. Findings include: Review of Resident #57's Face Sheet dated 2/6/18, revealed Resident #57 was a [AGE] year old male admitted to the facility on [DATE] and had the following diagnose: [MEDICAL CONDITION], delusional disorders, muscle weakness, difficulty walking and lack of coordination. Resident #57 was not his own responsible party. On 02/05/18 at 11:06 a.m., Resident #57 was observed up in a geriatric style chair (reclined chair with foot rest) in hall. Resident #57 was asked if chair was comfortable and he said no. Resident #57 could not say how long he was up or why he was uncomfortable. Resident #57 said he wanted to go to bed. Certified Nurse's Aide (CNA) O was asked if Resident #57 needed to go to bed because he was uncomfortable and CNA O said, No, if he goes to bed he will stand up, walk and fall. CNA O re-adjusted the Geri chair to a more reclined position. On 02/08/17 at 9:20 a.m., CNA O and CNA RR put Resident #57 in bed from his geriatric style chair. CNA's O and RR provided hygiene care. CNA's O and RR said Resident #57 could not stay in bed because he would get up and fall. Resident #57 was placed back in his Geri Chair, in a reclined position in the hall after care. During an interview on 2/12/18 at 9:50 a.m., the Minimum Data Set (MDS) (NAME)tered Nurse (RN) QQ said Resident #57 received his geriatric style chair from hospice in July 2017 and she completed a significant change assessment at that time. RN QQ was asked why the geriatric chair was not coded as a restraint at that time and QQ responded she did not think of it. RN QQ was not aware Resident #57 was able to walk in June 2017 with one assist and was not aware the geri chair prevented Resident #57 from standing when reclined. Resident #57 was in a standard wheelchair prior to the significant change in July. RN QQ reviewed the Care Area Assessment (CAA) part of MDS that gives assessment details to address decline. RN QQ could not locate any additional information on why Resident #57 was no longer able to use a standard wheel chair and was place in a chair he could not move. Review of Resident #57's Physical Therapy Discharge Note dated 6/8/17, reflected Resident #57 could walk 170 feet with a 2 wheeled walker and minimal assist of one person. During an interview on 2/12/18 at 2:00 PM, Therapy Director SS confirmed Resident #57 could walk 170 feet with a 2 wheeled walker and one person assist when Physical Therapy discharged him on 6/8/17. Therapy Director SS could not find the standard documentation that was to be provided to nursing staff with instructions to help maintain a resident's function when discharged from therapy. Therapy Director SS could not locate any documentation that would explain why nursing did not receive any instructions to continue to walk with Resident #57 when discharged from therapy on 6/8/17. Review of Resident #57's Physical Restraint assessment dated [DATE] and signed by RN CC documented the brand name of the geriatric chair is for positioning, it is not a restraint. During an interview on 2/12/18 at 2:00 PM with RN CC, Resident #57's Restraint Assessment completed by CC was reviewed along with fall incident reports that documented the intervention on 2 occasions to prevent falls was to recline Resident #57 in his geriatric wheel chair. RN CC said she was not aware Resident #57 was able to get out of a wheel chair or geriatric chair and when it was reclined he could not get out. RN CC said that was why she assessed the chair as a positioning device

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0636 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) on 7/7/18 and the geriatric chair was not assessed again. RN CC said she was not aware Resident #57 was able to walk with one person assist in June and did not know why Resident #57's functional status was not maintained after he was discharged from Physical Therapy. Review of Resident #57's Incident Report dated 8/28/17 at 12:30 PM, reflected, Resident attempted to get out of his recliner then staff assisted him to the floor as resident was sliding off the recliner. Did not hit his head to the floor. Under corrective action documented, Staff will have name of geriatric style chair tilted back whenever resident is in name of geriatric style chair unless resident is eating or drinking (This made the geriatric style chair a restraint as evidenced by documentation that Resident #57 could get out of the chair when sitting up and stand when it was not reclined, no order for this restraint or restraint evaluation was located at this time). Review of Resident #57's Incident Report dated 12/1/17 at 7:01 PM, reflected, Res (resident) at nurse's station in name of geriatric style wheel chair. Observed attempting to stand from chair, Resident's knee buckled and ended up on both knees on floor with feet in chair. Under corrective action documented, Must remain reclined between meals. (Restraining resident #57 to prevent falls, without an evaluation, orders or release times). Review of the facility Restraints policy dated 5/17, documented under procedures. 1. Prior to utilization of any restraint, the interdisciplinary group completes an evaluation of the patient including a review of hospital discharge records, transfer reports of other documents; an interview with the patient, family or patient representative about the patient's history and risk factors, previous interventions utilized and any medical evaluation of the presenting medical symptom necessitating the use of the restraint. (This information was not located, the restraint evaluation was not completed by the interdisciplinary group. The evaluation was complete by one person. The geriatric style chair was determined not to be a restraint by that one person not the group. (None of the other steps in the facility policy were followed).
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop and implement comprehensive, person-centered care plans for 5 residents (Resident #4, #15, #28, #38 and #59) of 25 reviewed for comprehensive care plans, from a total sample of 28 residents, resulting in the potential for inadequate care and unmet care needs. Findings include: Resident #4 Review of the facility Face Sheet, dated 2/7/18, and the annual Minimum Data Set assessment (MDS, an assessment to identify resident care needs), dated 1/17/18, reflected that Resident #4 was an [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected that she had a Brief Interview for Mental Status assessment (BIMS, a cognitive screening tool) of 13 out of 15, which indicated she was cognitively intact. She required one person extensive assist for bed mobility, dressing, eating, toilet use, personal hygiene and bathing. During an observation and interview on 2/6/18 at 10:29 AM, Resident #4 reported that she had difficulty brushing her teeth due to hand tremors and both hands not working well at times. She reported that facility staff did not always brush her teeth and that at times, she would go for weeks without having her teeth brushed. She also reported that staff helped her brush her teeth about once every two months. Plaque and debris were observed on her upper and lower front teeth. The resident reported that she was unsure if the staff were aware that she had difficulty brushing her teeth. In an interview on 2/7/18 at 3:04 PM, Certified Nurse Aide (CNA) FF reported that the resident knew she could do certain things but she wanted them done for her. CNA FF stated that Resident #4 could brush her own teeth if the toothbrush was put in her hands. If the resident stated she had a hard time brushing her teeth, CNA FF brushed them for her. On 2/8/17 at 11:09 AM, CNA T was observed giving Resident #4 a shower. CNA T reported that Resident #4 usually brushed her teeth on her own in her bathroom. The resident stated she was unable to independently brush her teeth and had not had them brushed yet that day. CNA T inquired about the reason, and the resident reported it was due to her hand tremors. After returning to the resident's room, CNA T brushed Resident #4's teeth. Resident #4 was observed spitting out blood in her saliva while having her teeth brushed. During an interview on 2/13/18 at 8:56 AM, (NAME)tered Nurse (RN) QQ reported that the ADL Care Plan was generated through the MDS process and was updated by the Interdisciplinary Team (IDT). RN QQ reported that MDS items such as bed mobility, transfers, toileting, eating and showers were automatically generated on the MDS based on CNA documentation of the areas. RN QQ also reported that the amount of assistance for bed mobility and transfers were specific on the care plan since the staff liked knowing how many people were needed for transfers. The Activities of Daily Living (ADL) section of the Kardex (CNA Care Guide), dated 2/12/18, reflected that the resident required one person assistance with bed mobility, one person assistance with a gait belt (a belt used around the waist for safety) for transfers and that she walked to the bathroom with a gait belt and a walker. The Kardex also reflected that the resident showered/bathed on Sunday's and Thursday's and that she preferred bed baths. The Kardex did not reflect the amount of assistance that the resident required for ADL's such as hygiene or grooming. The ADL Care Plan, initiated on 1/10/17, reflected goals of, Will not develop any complications related to decreased mobility and Will receive assistance necessary to meet ADL needs. Both goals had a Target Date of 5/12/18. The Interventions section of the care plan reflected, .Assist to bathe/shower as needed .Assist with daily hygiene, grooming, dressing, oral care and eating as needed . The interventions did not include specific information needed to inform care givers of the amount of assistance that the resident required to carry out ADL's. The facility policy titled, Interdisciplinary Care Planning, dated 11/2016, reflected, .Care Planning: The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive. The care plan should focus on: .planning for care to meet the patient's needs .The care plan should: .describe the services that the facility is to provide .Care Plan Components: .Intervention: Goals need to have interventions that help the patient meet the goal. Interventions identify specific, individualized elements of care, provided by staff, which help patients achieve their goals. Interventions are the instructions for delivering patient care and allow for continuity of care by staff. Just like goals, interventions are specific and measurable . Resident #15 According to a facility face sheet dated 2/8/18 at 4:11 PM, Resident #15 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Fall #1 - 11/8/17 Review of a facility investigation for Resident #15, a document titled Incident Report - Patient Involved dated 11/8/17 at 8:30 PM reflected, Resident (#15) was witnessed sitting on the floor in her bathroom. She stated she was trying to get up and fell . Prior to the incident resident was asked if she was ready for bed, she said no. When Certified Nurse's Aide (CNA) went to get her ready she put her in the bathroom, and told her (Resident #15) to call when she was done, but instead of resident putting on the call light when she was done, she tried to stand up on her own and fell on buttocks, skin tear on left elbow when checked her vitals (vital signs) B/P (blood pressure) was 69/40 (low). Resident was responding but couldn't hold herself up and keep conversation. She was very lethargic and she (Resident #15) as leaning to the right side. Physician notified. Orders received to send to ER (emergency room) for evaluation. This document reflected, Corrective Action: Resident will not be left in bathroom unattended. Review of a document for Resident #15, a Certified Nurse's Aide care guide dated 12/28/17, page 1 of 1, did not reflect that Resident #15 was not to be left in the bathroom unattended. Review of a care plan provided by the facility as the interventions in place after Resident #15's first fall, before her hospitalization after the second fall on 11/23/17 dated 8/1/17 reflected no new intervention to not leave Resident #15 unattended in the bathroom. Review of Resident #15's care plans dated 12/28/17 (post hospitalization following fall #2), 24 pages, there was no intervention not to leave Resident #15 in the bathroom unattended. Fall #2 11/23/17 Review of a facility investigation for Resident #15, a document titled Incident Report - Patient Involved dated 11/23/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) 8:30 PM (same time of day as fall #1) reflected, CNA transferring patient in sit to stand (mechanical lift) machine from shower chair to bed. Patient observed slowing letting go of handles and sliding down to floor. CNA and nurse lowered patient to the floor. Patient unresponsive for a few seconds and could not say where she was at or how she got to the floor. This document reflected, Corrective Action: Sent out to the emergency room for further evaluation. Review of Resident #15's care plans dated 12/28/17 (post hospitalization following fall #2), 24 pages, revealed that the intervention to use a total mechanical lift x 2 (times 2 persons) for transfers was not added to the care plan until 1/2/18. This intervention was added 5 days after Resident #15 returned from the hospital and 10 days after the fall with a fracture. Resident #28 According to a facility face sheet dated 2/12/18 at 2:46 PM, Resident #28 was a [AGE] year old male admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. On 02/05/18 at 01:48 PM an observation was made of Resident #28's urinal. Resident #28 was not present. An empty hand held urinal was observed on over bed table. No barrier was observed under this urinal. On 02/07/18 at12:59 PM, an observation of the Resident #28's room, Resident #28 was not present. An empty hand held urinal was observed on the bedside dresser. During an observation on 02/08/18 at 08:46 AM, Resident #28 was observed in bed. Over bed table was over his lap. An empty tray of food was in front of him. Resident #28 stated he is still hungry. Resident #28's empty hand held urinal was observed on the over bed table next to his food tray, again no barrier under the urinal was observed. During an interview and record review on 02/08/18 at 01:22 PM with UM CC, she stated a urinal should be on a barrier on the table and care planned as such. UM CC stated the facility tries to teach residents about urinal placement after use. UM CC confirmed that there is no care planning regarding urinal placement or teaching about placement for Resident #28. Resident #38 According to a facility face sheet dated 2/12/18 at 1:32 PM, Resident #38 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Review of a facility investigation for Resident #38, a document titled Incident Report - Patient Involved dated 5/17/17 at 6:30 AM reflected, Heard yelling for help, upon entering the room, the resident (#38) stated she fell ing trying to get her drink. Drink was on the tray table at upper right side of bed. Resident states severe pain in right shoulder and she states hitting her head on the floor, so did not move resident from position .send to hospital for evaluation. Intervention is med(ication review), UA (urinalysis) and CNS (culture and sensitivity) upon return. This documented also reflected, Corrective action: PT/OT (physical therapy, occupational therapy) evaluation and treatment, UA if indicated, medication review and education with staff and patient. Review of a care plan for Resident #38 provided by the facility as care plan to prevent another fall dated 6/13/15, At risk for falls due to history of recurrent falls, potential medication side effects, physical performance limitations including impaired balance, poor coordination, difficulty ambulating (walking), weakness, history of syncopal episode with falls, [MEDICAL CONDITION]. Resident had actual fall. Interventions dated 5/17/17 were, Medication review to be completed by IPC, PT/OT evaluation and treat if appropriate, and UA if not completed by hospital. There was no intervention to for education of resident nor what the education was. There was no immediate intervention formulated related to the root cause analysis of the fall to prevent another fall. According to The Fundamentals of Nursing ((NAME) and Perry, 6th Edition, 2005), Nursing interventions are prioritized to provide safe and efficient care .The client's mobility problem is an obvious priority because of its influence on skin integrity and risks for falls. The nurse plans individualized interventions based on the severity of risk factors and the client's developmental stage, level of health, lifestyle, and culture .nursing interventions are directed toward maintaining the client's safety in all types of settings. Nursing measures for providing a safe environment include health promotion, developmental interventions, and environmental interventions .To promote an individual's health, it is necessary for the individual to be in a safe environment to practice a life style that minimizes risk of injury. Resident #59 Weight Loss According to a facility face sheet dated 2/8/18 at 8:28 AM, Resident #59 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Resident #59 spoke Spanish and did not speak English well. Review of a Minimum Data Set assessment ((MDS) dated [DATE] reviewed on 02/08/18 at 10:26 AM with MDS coordinator QQ, she stated Section G for activities of daily living auto populates from certified nursing aide (CNA) documentation. Eating was reflected as 0/2 indicating Resident #59 was independent but needed assist of 1 person. MDS coordinator QQ stated the care plans were not driven by an MDS assessment but by the interdisciplinary team (IDT). During an interview on 02/07/18 at 02:55 PM with (NAME)tered Dietician (RD) N, he stated he spoke a little Spanish. When asked how he assessed Resident #59's preferences he stated the last assessment, touched on it here and there when the volunteer was here. RD N stated he has talked to Resident #59's family. Resident #59 liked authentic Mexican food. He stated family was bringing some in. Resident #59 liked spicy foods. RD N confirmed that Resident #59 could have a regular diet. RD N stated Resident #59 was ill last (NAME)h 2017, and had fluid retention, lung problems. When Resident #59 returned she was on thickened liquids and a mechanical soft diet. RD N asked speech therapy to evaluate Resident #59's swallowing abilities and a month later a regular diet was restarted. RD N stated Resident #59 was eating better on a regular diet. Resident #59 loved ensure plus (a liquid diet supplement) so he wanted to get a supplement and that was not possible when Resident #59 was on a thickened liquid diet. RD N stated Resident #59 did trigger for a significant weight loss with fluid loss (from diuretics) and intake. RD N stated Resident #59 likes fried eggs, scrambled eggs, cereal. Resident #59 is on Ensure plus but no fortified foods. RD N stated he did try to add extra butter to her diet when he can. RD N stated Resident #59 could have a hot sauce. RD N stated there was a care conference regarding food. RD N stated they try and cook for her. RD N stated Resident #59 needed assistance when she was ill but she is now better. Resident #59 liked to eat with her fingers. RD N has tried serving sandwiches. Resident #59 triggered for significant weight loss [DATE]. RD N stated the texture of the mechanical soft diet was the problem so finally got swallowing study on 11/10/17. Resident #59 refused magic cup when back from hospital (thickened liquid). RD N was asked what interventions were tried after significant loss triggered. RD N stated they concentrated on what she ate and eats best at breakfast, doubled up on eggs. RD N stated they have tried having Resident #59 eat with others doesn't want to. RD N was asked if anyone came to feed her or encourage her. RD N stated the volunteer was in and let him know what she ate. RD N stated no encouragement is given, Resident #59 ate at own pace, did her own thing. RD N was told of today's observation and Resident #59 was given no encouragement or alternative choice. RD N confirmed there was no care plan intervention in August to prevent more weight loss, there was no direction that if Resident #59 ate less than a certain percentage that an alternative be offered. RD N stated Resident #59 was at borderline healthy vs unhealthy with a 20.4 BMI. 111 lb. after fluid loss. Resident #59 is now 97.4 lbs. RD N stated Resident #59 was stable since November 2017. Review of a Minimum Data Set ((MDS) dated [DATE] with RD N reflected Resident #59 as, independent but assist of 1 '0/2'. Review of Resident #59's current care plan revealed Resident #59 was assist as needed. RD N stated Resident #59's calorie need was 1100 to 1300 calories needed. RD state Resident #59 is consuming 1000 calories a day RD N confirmed a food acceptance record (FAR) is being kept to monitor Resident #59's intake. RD N stated it depended on the meal, the acceptance averages 50 %. RD N stated the FAR doesn't list type of intake such as protein percentage, starch percentage, fruit and vegetables, etc. RD N stated he doesn't go on intake record to monitor intake, RD N stated he was hands on, he checked with Resident #59 daily. Review of a care plan dated 9/21/15 for Resident #59 provided by (NAME)tered Dietician (RD) N as interventions to prevent weight loss reflected, Nutritional status as evidenced by potential weight loss/gain related to possible fluid fluctuations. Resident has history of significant weight loss, underweight. Dated revised on 2/2/18 by RD N. Interventions: Encourage and assist as needed to consume foods and/or supplements and fluids ordered, dated 9/21/15. Resident #59 was noted as having a significant weight loss on 8/17/17. No new interventions to prevent further weight loss was added to the care plan until 10/27/17 and it was a revision of a previous intervention, Provide diet as ordered: Regular cut meats in small bites. Gravy/sauce for meals initiated on 12/16/16. Actvities Resident #59 During an interview on 02/07/18 at 12:35 PM with Activities Director (AD) G, it was revealed that in October 2017 an activities assessment was completed for Resident #59. AD G stated one of the volunteers translated during the assessment. AD G stated Resident #59 liked animals (the facility has a dog that visits once week), she liked to color and had colored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) pencils and coloring pages in her room, painting, BINGO which she was invited to but does not come. Resident #59 has the Spanish channel on TV, liked to exercise, garden, liked music, family and facility parties/socials. Resident #59 liked bible reading and received communion from her denomination occasionally. Resident #9 was visited daily by volunteer that is Spanish speaking. Resident #59's log of activities were requested AD G stated she keeps the logs and Activity Assistant (AA) AA fills out the logs. AA AA marks unavailable on Resident #59's log when with a volunteer or sleeping. AD G stated Resident #59 liked sitting in doorway and watching. AD G stated she has talked to family and they have encouraged Resident #59 to attend more activities. Review of a facility document for Resident #59 titled, Recreation/Activity (NAME)luation dated 10/12/17 at 1:53 PM reflected Resident #59, liked to keep busy, she liked to spend time relaxing. Enjoyed independent leisure activities. Liked dogs and cats. Current interested in coloring and painting. Interested in Bingo. Expressed an interest in group leisure activities. Participated in outdoor leisure activities. Interested in facility and family parties. Resident #59 liked word searches in Spanish, talking in Spanish only, Resident #59 did not say she was interested in watching TV. Review of a facility care plan for Resident #59 dated 10/7/15 and revised 1/22/18 reflected, Participation in activities is limited due to language barrier. Patient speaks only fluent Spanish. Patient enjoyed activities such as arts, crafts (coloring), Bingo, cards, watching Spanish news and TV channels, gardening, pet visits, movies, listening to music, jigsaw and word search puzzles, reading from her Bible, and socializing with other Spanish speaking residents and volunteers. Interventions, encourage family/friends to bring in items of interest, encourage interactions with others that speak same language, offer activity choices in line with interests and capabilities, post calendar in room and have staff/family translate when appropriate, praise efforts to participate, provide leisure materials such as coloring pages that resident can use in her room, provide phone number for translation service and translation materials in room, reassure are always welcome to attend any group activities of choice, and transport to/from group activities. All interventions are dated 10/22/15. Only reassure are always welcome to attend any group activities of choice is dated 2/2/17. The Purpose of the Written Care Plan: Care plans provide direction for individualized care of the client. A care plan flows from each patient's unique list of [DIAGNOSES REDACTED]. Continuity of care. The care plan is a means of communicating and organizing the actions of a constantly changing nursing staff. As the patient's needs are attended to, the updated plan is passed on to the nursing staff at shift change and during nursing rounds. Care plans help .documentation. The care plan should specifically outline which observations to make, what nursing actions to carry out, and what instructions the client or family members require. They serve as a guide for assigning staff to care for the client. There may be aspects of the patient's care that need to be assigned to team members with specific skills. (http://www.rncentral.com/nursing-library/careplans/)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide tube feeding medications according to professional standards for 1 resident (Resident #32) out of 1 Resident observed for tube feeding medication pass out of a total of 7 Residents observed for medication pass, resulting in the potential for Resident #32's feeding tube to be clogged and or an adverse medication reaction. Findings include: Review of Resident #32's Face Sheet revealed she was a [AGE] year old female admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED].#32 was not her own responsible party. On 2/6/18 at about 9:50 a.m., Resident #32 was observed in bed. Resident #32 could shake her head yes and no to questions. On 2/6/18 (NAME)tered Nurse (RN) H was observed setting up the following medications for Resident #32: [MEDICATION NAME] 250 mg/5 ml (5 ml liquid), [MEDICATION NAME] -[MEDICATION NAME] 7.5 in 15 ml (15 ml liquid), Citaloprim 20 mg tablet, [MEDICATION NAME] 50 mg in 5 ml (10 ml liquid dispensed) [MEDICATION NAME] 10 mg tablet, Carvediolol 6.25 mg tablet, Losartan Potassium 50 mg tablet. All tablets were crushed and placed in a cup with 5 ml of water. Each medication had an individual medicine cup. RN H filled a plastic cup with an unknown amount of water and placed medications and water cup on Resident #32's bedside table. RN H checked tube feed placement by using a syringe to withdraw approximately 5 cc of residual stomach fluid. RN H flushed the feeding tube with 30 cc of water than started placing the medications in the cup in the syringe. At times the medication was going very slow into Resident #32's tube so RN H would use the syringe plunger to push the medications into the tube. RN H did not flush with water between 3 of the 7 medications (not sure what medications were in the 3 cups that did not get a water flush). After RN H completed giving Resident #32 her medications, RN H was asked which medications do not require a flush between them and RN H said, they all do, did I forget. RN H was asked if the medications were to be given by gravity or could be pushed and RN H said she was told in training she could push the medications for Resident #32 because her tube was slow. Review of the facility Enteral Tubes: Medication Administration policy dated 2/2012, revealed under procedure item #13 Instill each medication separately, flushing between each medication with a minimum of 5-10 ml of water to prevent tube occlusions. Facility policy did not indicate all medications were to be provided by gravity. Director of Nursing (DON) B was asked if medications could be pushed or were to be given by gravity on the morning of 2/7/18 and DON B said all tube feeding medications were to be given by gravity. Review of RN H's Medication Management Skills (NAME)luation revealed RN H demonstrated the skill/technique for administering enteral medication according to manufacturer's instruction (this did not indicate that medications were to be given pushed or gravity or if medications required a water flush. This skill was signed off on 1/4/18.
F 0676 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide the care and services to prevent physical decline for 1 resident (Resident #57), out of 28 residents reviewed for care, from a total sample of 28 residents, resulting in Resident #57 having an avoidable decline in walking and physical movement. Findings include: Review of Resident #57's Face Sheet dated 2/6/18, revealed Resident #57 was a [AGE] year old male admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. Resident #57 was not his own responsible party. Review of Resident #57's Physical Therapy Discharge Note dated 6/8/17 revealed Resident #57 could walk 170 feet with a 2 wheeled walker and minimal assist of one person. During an interview on 2/12/18 at 2:00 PM, Therapy Director SS confirmed Resident #57 could walk 170 feet with a 2 wheeled walker and one person assist when Physical Therapy discharged him on 6/8/17. SS could not find the standard documentation that was provided to nursing with instructions to help maintain a Residents function when discharged from therapy. SS could not locate any documentation that would explain why nursing did not receive any instructions to continue to walk with Resident #57 when discharged from therapy on 6/8/17. Review of Resident #57's Minimum Data Set (MDS), a nursing assessment, dated 1/1/18 revealed Resident #57 was no longer able to walk and required extensive assistance of 2 people for transfers. Resident #57 was observed being transferred with an electronic lift (total assist with transfer requiring 2 people on 2/8/18 at 9:20 a.m. This should be coded as total assist of 2 on the MDS). On 2/05/18 at 11:06 a.m., Resident #57 was observed up in a geriatric style chair (reclined chair with foot rest) in hall. Resident #57 was asked if the chair was comfortable and he said no. Resident #57 could not say how long he was up or why he was uncomfortable. Resident #57 said he wanted to go to bed. Certified Nurse's Aide (CNA) O was asked if Resident #57 needed to go to bed because he was uncomfortable and CNA O said, no, if he goes to bed he will stand up, walk and fall. CNA O readjusted the Geri chair to a more reclined position. On 2/08/17 at 9:20 am. CNA O and CNA RR put Resident #57 in bed from his geriatric style chair using a electronic lift. CNA's provided hygiene care. CNA's said Resident #57 could not stay in bed because he would get up and fall. Resident #57 was place back in his Geri Chair, in a reclined position in the hall after care. During an interview on 2/12/18 at 9:50 a.m., Minimum Data Set (MDS) (NAME)tered Nurse (RN) QQ said Resident #57 received his geriatric style chair from hospice and in July 2017 and she completed a significant change assessment at that time. RN QQ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0676 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 8) was asked why the geriatric chair was not coded as a restraint at that time and QQ responded she did not think of it. RN QQ reviewed the significant change documentation and could not find any information on Resident #57 ability to walk in June or reason for placing Resident #57 in a geri chair verses a standard wheel chair. Review of Resident #57's Physical Restraint assessment dated [DATE] and signed by RN CC documented the brand name of the geriatric chair is for positioning, it is not a restraint. During an interview with RN CC on 2/12/18 at 2:00 PM Resident #57's Restraint Assessment completed by CC was reviewed along with fall incident reports that documented the intervention on 2 occasions to prevent falls was to recline Resident #57 in his geriatric wheel chair. RN CC said she was not aware Resident #57 was able to get out of a wheel chair or geriatric chair and when it was reclined he could not get out. CC said that was why she assessed the chair as a positioning device on 7/7/18 and the geriatric chair was not assessed again. CC said she was not aware Resident #57 was able to walk with one person assist in June and did not know why Resident #57's functional status was not maintained after he was discharged from Physical Therapy. Review of Resident #57's Incident Report dated 8/28/17 at 12:30 PM, documented, Resident attempted to get out of his recliner then staff assisted him to the floor as resident was sliding off the recliner. Did not his head to the floor. Under corrective action documented, Staff will have (name of geriatric style chair) tilted back whenever resident is in (name of geriatric style chair) unless resident is eating or drinking (This made the geriatric style chair a restraint as evidenced by documentation that Resident #57 could get out of the chair when sitting up and stand when it was not reclined, no order for this restraint or restraint evaluation was located at this time). Review of Resident #57's Incident Report dated 12/1/17 at 7:01 PM, documented, Res (resident) at nurse's station in (name of geriatric style wheel chair). Observed attempting to stand from chair, Resident's knee buckled and ended up on both knees on floor with feet in chair. Under corrective action documented, Must remain reclined between meals. (Restraining resident #57 to prevent falls, without an evaluation, orders or release times).
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate oral care to 1 resident (Resident #4) of 25 reviewed for activities of daily living, from a total sample of 28 residents, resulting in poor oral hygiene. Findings include: Review of the facility Face Sheet, dated 2/7/18, and the annual Minimum Data Set assessment (MDS) (an assessment to identify resident care needs), dated 1/17/18, reflected that Resident #4 was an [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected that she had a Brief Interview for Mental Status assessment (BIMS) (a cognitive screening tool) of 13 out of 15, which indicated she was cognitively intact. She required one person extensive assist for bed mobility, dressing, eating, toilet use, personal hygiene and bathing. During an observation and interview on 2/6/18 at 10:29 AM, Resident #4 reported that she had difficulty brushing her teeth due to hand tremors and both hands not working well at times. She reported that facility staff did not always brush her teeth and that at times, she would go for weeks without having her teeth brushed. She also reported that staff helped her brush her teeth about once every two months. Plaque and debris were observed on her upper and lower front teeth. The resident reported that she was unsure if the staff were aware that she had difficulty brushing her teeth. In an interview on 2/7/18 at 3:04 PM, CNA FF reported that the resident knew she could do certain things but she wanted them done for her. CNA FF stated that Resident #4 could brush her own teeth if the toothbrush was put in her hands. If the resident stated she had a hard time brushing her teeth, CNA FF brushed them for her. On 2/8/17 at 11:09 AM, CNA T was observed giving Resident #4 a shower. CNA T reported that Resident #4 usually brushed her teeth on her own in her bathroom. The resident stated she was unable to independently brush her teeth and had not had them brushed yet that day. CNA T inquired about the reason, and the resident reported it was due to her hand tremors. After returning to the resident's room, CNA T brushed Resident #4's teeth. Resident #4 was observed spitting out blood in her saliva while having her teeth brushed. The Activities of Daily Living (ADL) section of the Kardex (CNA Care Guide), dated 2/12/18, reflected that the resident required one person assistance with bed mobility, one person assistance with a gait belt (a belt used around the waist for safety) for transfers and that she walked to the bathroom with a gait belt and a walker. The Kardex also reflected that the resident showered/bathed on Sunday's and Thursday's and that she preferred bed baths. The Kardex did not reflect the amount of assistance that the resident required for ADL's such as hygiene or grooming. The ADL Care Plan, initiated on 1/10/17, reflected goals of, Will not develop any complications related to decreased mobility and Will receive assistance necessary to meet ADL needs. Both goals had a Target Date of 5/12/18. The Interventions section of the care plan reflected, .Assist to bathe/shower as needed .Assist with daily hygiene, grooming, dressing, oral care and eating as needed . The interventions did not include specific information needed to inform care givers of the amount of assistance that the resident required to carry out ADL's. Review of a progress note by SW W on 5/24/17 at 4:00 PM reflected, (Dentist Name) saw res. (resident) today for evaluation and indicated no treatment at this time. Recommend to re-visit in 6 months. Review of a progress note by Social Worker (SW) W on 11/29/17 at 4:57 PM reflected that the resident was seen by the dentist today. The note reflected that an oral examination was performed and the resident had non-restorable decay to tooth #10. The note also reflected that the recommendation was extraction as needed and a follow-up in 6 months. A dental consult report for 11/29/17 at 10:41 AM reflected that tooth #10 had non restorable decay, there was heavy plaque on the teeth and that the resident needed staff assistance for oral hygiene. During an interview on 2/13/18 at 8:56 AM, (NAME)tered Nurse (RN) QQ reported that CNA's were instructed that everyone needed oral care in the morning and at bedtime. She stated that the facility was doing education consistently with CNA's that oral care needs to be done .We have meetings every day and go over concerns. (NAME)l care is an overall deficient practice here. We know that it is an issue . During an interview on 2/13/18 at 10:16 AM, CNA K stated that any education was normally given facility-wide. She did not recall any recent education regarding oral care. The facility policy titled, AM CARE, dated of 12/2009 reflected, .Procedure .10. Assist with mouth care . The facility policy titled, HS CARE-PM CARE, dated 12/2009 reflected, .Procedure .7. Assist with mouth care .
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide meaningful, individualized activities for 3 residents (Resident #56, 57 and 59) out of 4 residents reviewed for meaningful activities from a total sample of 28 residents resulting in the potential for boredom, isolation, depression and decreased feelings of self-worth and lack of ability to attain and maintain the highest practicable level of wellbeing. Findings include: Resident #59 According to a facility face sheet dated 2/8/18 at 8:28 AM, Resident #59 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Resident #59 spoke Spanish and did not speak English well. During an interview on 02/07/18 at 12:35 PM with Activities Director (AD) G, it was revealed that in October 2017 an activities assessment was completed for Resident #59. AD G stated one of the volunteers translated during the assessment. AD G stated Resident #59 liked animals (the facility has a dog that visits once week), she liked to color and had colored pencils and coloring pages in her room, painting, BINGO which she was invited to but does not come. Resident #59 has the Spanish channel on TV, liked to exercise, garden, liked music, family and facility parties/socials. Resident #59 liked bible reading and received communion from her denomination occasionally. Resident #9 was visited daily by volunteer that is Spanish speaking. Resident #59's log of activities were requested AD G stated she keeps the logs and Activity Assistant (AA) AA fills out the logs. AA AA marks unavailable on Resident #59's log when with a volunteer or sleeping. AD G stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) Resident #59 liked sitting in doorway and watching. AD G stated she has talked to family and they have encouraged Resident #59 to attend more activities. Review of a facility document for Resident #59 titled, Recreation/Activity (NAME)luation dated 10/12/17 at 1:53 PM reflected Resident #59, liked to keep busy, she liked to spend time relaxing. Enjoyed independent leisure activities. Liked dogs and cats. Current interested in coloring and painting. Interested in Bingo. Expressed an interest in group leisure activities. Participated in outdoor leisure activities. Interested in facility and family parties. Resident #59 liked word searches in Spanish, talking in Spanish only, Resident #59 did not say she was interested in watching TV. Review of a facility care plan for Resident #59 dated 10/7/15 and revised 1/22/18 reflected, Participation in activities is limited due to language barrier. Patient speaks only fluent Spanish. Patient enjoyed activities such as arts, crafts (coloring), Bingo, cards, watching Spanish news and TV channels, gardening, pet visits, movies, listening to music, jigsaw and word search puzzles, reading from her Bible, and socializing with other Spanish speaking residents and volunteers. Interventions, encourage family/friends to bring in items of interest, encourage interactions with others that speak same language, offer activity choices in line with interests and capabilities, post calendar in room and have staff/family translate when appropriate, praise efforts to participate, provide leisure materials such as coloring pages that resident can use in her room, provide phone number for translation service and translation materials in room, reassure are always welcome to attend any group activities of choice, and transport to/from group activities. All interventions are dated 10/22/15. Only reassure are always welcome to attend any group activities of choice is dated 2/2/17. Review of documents titled, Daily Recreational/Activity Participation Documentation for Resident #59 are as follows: December 2017 there are U's (meaning unavailable) for Arts and crafts on 12/2, 12/4, 12/6, and 12/11. No further documentation regarding arts and crafts. There are U's for BINGO on 12/1, 12/2, 12/5, 12 7, 12/8, 12/9, 12/10, 12/12, 12/14, 12/15, 12/16, 12/19, 12/21, 12/22, 12/24, 12/26, 1229, 12/30 and 12/31. Cards/Games there are U's for 12/1, 12/5, 12/6, 12/11, 12/12, 12/15, 12/18, 12/19, 12/22, 12/26 and 12/19. Movies U's are on 12/9, and 12/13. Music and Singing U's on 12/7, 12/13, 12/14, 12/21 and 12/22. An A (meaning active) on 12/17 and 12/19. Socializing and Television was marked every day as I (for independent). Exercise was marked U on 12/5 and 12/12. Pet visits had no documentation. Puzzles had no documentation. Special theme events had U's on 12/4, 12/6, 12/7, 12/8 was an A, 12/9, 12/10, 12/16, 12/17 was an A as was 12/19, 12/21 and 12/27. Social Programs was marked U on 12/3. Volunteer visits marked I on 12/1, 12/5 to 12/8, 12/11 to 12/15, 12/18 to 12/22, and 12/27 to 12/28.<BR/(NAME)uary 2018 Areas above all marked U as before or I in socializing, television and volunteer visits. Pet visit A on 1/11. This was the only A in January. February 2018 Volunteer visit A on 2/1, 2/5 and 2/6. Socializing was marked as I Movie, Music/singing bingo, exercise was marked U sporadically. Resident #59's activity logs were rarely marked R for refused indicating the activity had been offered to the resident. Review of facility Activities calendars for December 2017, January 2018 and February 2018 reflected many opportunities for Bingo, Poker club, black jack, music, exercise, arts such as ceramics, resident parties, movies, crafts that Resident #59 had expressed an interest in. Resident #45 Review of Resident #45's Face Sheet dated 2/8/18, revealed he was an [AGE] year old male admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. On 02/05/18 at 9:57 a.m. Resident #45 complained not remembering when activities were offered and said he would go if staff came to get him. Resident #45 said he liked crafts and board games. On 02/08/18 at 11:34 AM Activity Director G said she was not aware Resident #45 was not able to remember the activity schedule and wanted assistance getting to activities. Review of Resident #45's Daily Recreation/Activity Participation Documentation for December 2018 documented Resident #45 participated in movies 2 times, special and theme events 2 times, sensory stimulation 1 time and puzzles 3 times. Board games and crafts did not appear as items offered during December 2017. Review of Resident #45's Daily Recreation/Activity Participation Documentation for January 2018 documented Resident #45 only participated in movies 1 time, and pet visits 3 times. Board games and crafts did not appear as items offered during January 2018. Resident #56 Review of Resident #56's Face Sheet dated 2/6/18 revealed Resident #56 was a [AGE] year old female admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. Resident #56 was not her own responsible party. Resident #56 was observed 2/05/18 at 11:29 a.m. in geriatric style chair (lazy boy style chair with small wheels for dependent mobility) in her room by window sleeping. No television/radio or other activity being provided. Review of Resident #56's Recreation/Activity (NAME)luation dated 10/9/17 revealed Resident #56 liked to keep busy, liked to spend time relaxing and enjoyed independent leisure activities, and dogs. Current interest included facility parties, television/radio, talking/conversation and Jehovah's Witness for religious involvement. Review of Resident #56's Daily Recreation/Activity Participation Documentation for February 2018 documented on 2/5/18 (day of observation above) that Resident #56 was independent with socializing and television. During an interview with Activity Director G on 02/08/18 at 11:34 a.m. AD G provided the activity evaluation and activity participation list for 3 month for Resident #45. AD G said she marked socialization and television based on she thought nursing staff was providing this. AD G did not have any first hand knowledge that these activities were provided or when they would have been provided. Review of Resident #56's Daily Recreation/Activity Participation Documentation for December 2017 revealed Resident #56 attend 4 special and theme events and attended music and singing 5 time. There was no indication of any other activities provided and participated in for the month of December. Review of Resident #56's Daily Recreation/Activity Participation Documentation for January 2018 revealed Resident #56's had 3 pet visits, and 4 spiritual/religious activities. There was no indication of any other activities provided and participated in for the month of January. Resident #57 Review of Resident #57's Face Sheet dated 2/6/18, revealed Resident #57 was a [AGE] year old male admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. Resident #57 was not his own responsible party. on 2/05/18 at 11:06 a.m. Resident #57 was observed up in a geriatric style chair (reclined chair with foot rest) in hall. Resident #57 was asked if chair was comfortable and he said no. Resident #45 could not say how long he was up or why he was uncomfortable. Resident #57 said he wanted to go to bed. Certified Nurse's Aide (CNA) O was asked if Resident #45 needed to go to bed because he was uncomfortable and CNA O said, no, if he goes to bed he will stand up, walk and fall. CNA O readjusted the Geri chair to a more reclined position. On 2/08/17 at 9:20 am. CNA O and CNA RR put Resident #57 in bed from his geriatric style chair. CNA's provided hygiene care. CNA's said Resident #57 could not stay in bed because he would get up and fall. Resident #57 was place back in his Geri Chair, in a reclined position in the hall after care. No activities, music or television could be seen in the hall. On 02/08/18 at 11:34 AM Activity Director G provided an activity evaluation and activity participation list for 3 month for #57. G said she was marking socialization and television based on she thought nursing staff was providing this. G said she did not observe or make sure socialization or television was provided on the days she marked these items on the Residents participation schedules. G stated activities are to be offered every shift but G worked 8:00 a.m. to 4:30 p.m. and G only had one staff person that worked the same hours. Review of Resident #57's Daily Recreation/Activity Participation Documentation for December 2017 revealed Resident #57

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) attend music/singing 3 times, and special theme events 5 times. There was no indication of any other activities provided and participated in for the month of December. Review of Resident #57's Daily Recreation/Activity Participation Documentation for January 2018 revealed Resident #57's had 2 pet visits and attended spiritual/religious sanctities 2 times. There was no indication of any other activities provided and participated in for the month of January.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform complete neurological assessments after falls for 2 residents (Resident #38 and #53) and failed to appropriately assess and monitor 2 residents (Resident #15 and #42) of 28 reviewed for quality of care, from a total sample of 28, resulting in residents not receiving care and treatment in accordance with professional standards of practice and unrecognized changes in condition. Findings include: Resident #42 Review of the medical record reflected that Resident #42 was a [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the medical record and advance directives reflected that the resident was a full code, which indicated that her wishes were for life-saving measures. Record review of a progress note dated [DATE] at 10:00 AM reflected, called into room by cena (competency evaluated nurse aide) at 7:40 am, resident noted with no resp.(respirations) or pulse, code blue called and CPR was initiated, 911, (Physician Group), family and manager on call all contacted, (ambulance company), fire and police arrived, code continued until 8:06am when it was stopped and time of death was pronounced after (paramedics) contacted hospital and order was made to stop CPR, family, (Physician group), manager notified of death, police in contact with M.E. (medical examiner) and ok to release body to funeral home, daughter here at 9:15am, awaiting funeral home staff for release of body. Record review of a progress note by Physician's Assistant (PA) VV on [DATE] at 11:21 PM reflected that the resident was seen for [MEDICAL CONDITION]. The note reflected that her Brain Natriuretic Peptide (BNP) was over 3,000 (BNP is a laboratory test that measures levels of a protein made by the heart and blood vessels. The reference range for the result is less than or equal to 99). The note also reflected that her Creatinine was 3.4 (Creatinine is a laboratory test that measures a waste product from the normal breakdown of muscle tissue that is filtered through the kidneys. The reference range for the result is 0.600 to 1.200). Documentation reflected that the resident was more confused than her baseline and that a care conference needed to be set up with the daughter to discuss options, including hospice versus renal consult and [MEDICAL TREATMENT]. A progress note documented by Social Worker (SW) W on [DATE] at 12:05 PM reflected that the PA requested to speak with the DPOA (durable power of attorney) regarding the plan of care and medical status. A teleconference was set up with the DPOA for [DATE]. During a phone interview on [DATE] at 2:13 PM, DPOA UU reported that she had not been notified of changes of changes in condition at all times. She reported that the SW had called her (on [DATE]) to say that someone wanted to talk to her about the resident's [MEDICAL CONDITION]. DPOA UU acknowledged that someone was going to call her back on [DATE] because the timing was not good that day. She reported she had not been notified that the resident's condition was declining and that nobody had suggested to send the resident to the hospital. DPOA UU reported that she would have wanted the resident sent to the hospital for evaluation and treatment if she had known of changes in condition. She stated, I have always sent her to the hospital. She re-stated that SW had stated they wanted to talk about changes. Referring to [DATE], DPOA UU reported, They called me at 8:00 AM to let me know there was a change in condition. They called me at 8:14 AM to let me know that my mom was dead. Record review of laboratory testing reflected that a Comprehensive Metabolic Panel (CMP) was drawn on [DATE] at 12:20 PM. Creatinine was 2.454 and the carbon [MEDICATION NAME] level was 22.0 (the reference range was 21.0 to 31.0). On [DATE] at 6:30 AM, a CMP was drawn and reflected a creatinine of 3.140 and a carbon [MEDICATION NAME] of 16.0. A BNP test on [DATE] at 6:30 AM reflected a result of 1,715.0. A CMP was drawn on [DATE] at 6:50 AM. The creatinine level was 3.694 and carbon [MEDICATION NAME] was 16.0. The BNP result was 3,594.3. The lab report reflected a handwritten note by PA VV that a care conference with the family was needed. During a phone interview on [DATE] at 4:20 PM, PA VV reported that in the few weeks prior to her passing away, Resident #42 had been declining and overall was not doing well. PA VV reported that she completed her documentation from home and had not seen the patient at the actual time her progress note for [DATE] was documented. She reported she wanted to set up a conference with the daughter/DPOA to discuss hospice. PA VV reported she spoke to the SW about setting up a care conference with the daughter/DPOA, and she passed away over the weekend, before the care conference. PA VV stated, I was moving towards making this patient comfortable. She was declining. When asked if an elevated BNP would have necessitated a call to the DPOA, PA VV reported, Yes, that is what I did. (Documentation in the medical record reflected that SW W, who was not qualified to discuss laboratory results or medical conditions, made a phone call to the daughter.) During the same interview on [DATE], PA VV stated that diuresing the resident (giving medication to remove excess fluid from the body) would not have made a difference. PA VV reported that [MEDICAL TREATMENT] would have made a difference for the resident and that it could have been started in the hospital. PA VV stated that she would have been on board with sending the resident to the hospital but would have advocated that it was a Band-Aid. She stated that in the past, the DPOA did not want [MEDICAL TREATMENT], she wanted aggressive treatment. PA VV reported that at the time she evaluated the resident on [DATE], she was clinically stable. She reported clinical presentation that would have warranted a transfer to the hospital included increased respirations, low blood pressure, respiratory distress, increased heart rate and increased confusion. During a phone interview on [DATE] at 9:18 AM, Licensed Practical Nurse (LPN) X reported that earlier in the week of Resident #42's death, if she was having difficulty breathing, oxygen was put on her. She reported that on [DATE], she received report that the resident had some respiratory problems and to monitor her oxygen saturation levels. During a phone interview with (NAME)tered Nurse (RN) OO on [DATE] at 9:39 AM, she reported that she received report from LPN WW on then morning of [DATE] that the resident had pursed lip breathing during the night and that maybe she was short of breath. She was also told that oxygen was applied during the night, which gave her a little relief. RN OO reported that she saw the resident at approximately 6:30 AM on [DATE], as she was passing by Resident #42's room. RN OO stated that she could see the resident breathing at that time. RN OO reported that on the morning of [DATE], Certified Nursing Assistant (CNA) AAA was passing linens and told RN OO that something was not right with Resident #42 and to go to the room. RN OO reported that the resident was not breathing so she started the code process right away. RN OO stated, I knew she was declining a little but did not expect to walk into that. During a phone interview on [DATE] at 10:23 AM, LPN WW reported that she worked with Resident #42 overnight on [DATE] and into the morning of [DATE]. She reported that the resident did pursed lip breathing sometimes. LPN WW stated that Resident #42 began pursed lip breathing on her shift. She stated that she applied 1 liter of oxygen and told the CNA's to keep an eye on her and tell her if there was anything different. She stated she told the CNA's to notify her of any distress, if she was in more distress and increased confusion. She reported that the oxygen saturation was at 96% that night, so she was not personally worried about the resident. During the same interview, LPN WW reported the resident seemed more comfortable, and the pursed lip breathing had resolved after oxygen was applied. LPN WW reported that she elevated the head of the bed, checked the resident frequently and checked her vital signs and oxygen saturation level. She reported there was not a physical assessment of the resident during her shift because the resident was not in distress. LPN WW stated, I did not listen to her lungs because she was at 96% so I was not worried. She reported that she had not contacted the DPOA during her shift that night and stated, I assumed that was already done. LPN WW reported she did not personally report a change in condition to the doctor because she did not feel pursed lip breathing was a change for the resident. LPN WW stated she had first noticed pursed lip breathing that Thursday ([DATE]). LPN WW reported that she had not applied oxygen to Resident #42 in the past, prior to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 11) shift on [DATE]. The medical record did not include documentation that the resident had pursed lip breathing. LPN WW had not documented any assessment of the resident in the progress notes. Review of the Medication Administration Record (MAR) and the Treatment Administration Records (TAR) for [DATE] and February 2018 reflected an order for [REDACTED]. Documentation did not reflect that the resident had been placed on oxygen at any time. Review of the vital signs summary reflected that vital signs of temperature, pulse, respirations and blood pressure had last been obtained on [DATE] at 8:05 PM. The last oxygen saturation was documented as 98% while breathing room air on [DATE] at 8:35 PM. During an interview on [DATE] at 3:14 PM, Medical Doctor (MD) V reported that an elevated BNP would be considered a change in condition. He reported that clinically, if the resident was short of breath, had a heart rate greater than 100 beats per minute, a respiratory rate greater than 20 breaths per minute or appeared to be in respiratory distress, he would have recommended that she was sent to the hospital. He further stated that with any one of the above mentioned symptoms, he would have likely sent her to the hospital. He stated that he would have wanted a current set of vital signs to make the determination. MD V also stated that a determination could not have been made regarding her clinical presentation without a recent set of vital signs. MD V stated that he last examined Resident #42 on [DATE], and at that time, he did not feel that she was end stage in her life. He also reported he did not feel she was a hospice candidate at that time. During an interview on [DATE] at 12:47 PM, MD V reported that he would have expected to be notified during the night about pursed lip breathing if he was on-call. He stated, Honestly they should have sent her out .If someone has pursed lip breathing, they need to be sent out (to the hospital). MD V reported that the conversation with the survey team was the first time he had been notified that the resident had pursed lip breathing. He stated that his expectations of a nurse in regards to monitoring someone with pursed lip breathing would have included monitoring respiratory rate and oxygen saturation levels while on and off oxygen, an assessment of the respiratory effort and listening to lung sounds. MD V stated, If I am called for respiratory distress, I send the patient out .We were treating her appropriately based on labs, but based on pursed lip breathing, I would have sent her out . Review of the facility policy titled, CHANGE IN CONDITION with a date of ,[DATE], reflected the purpose was to provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications. The policy also reflected, .immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed . During an interview on [DATE] at 10:08 AM, CNA SS reported that she cared for Resident #42 overnight on [DATE] and that she did not take any vital signs for the resident. She reported that the resident was breathing fine. During an interview on [DATE] at 10:15 AM, CNA AAA reported that she got report from RN OO that the resident had oxygen on and had trouble breathing during the night. When AAA entered Resident #42's room, she turned the light on and called Resident #42's name. She reported the resident was not moving so she called for RN OO. AAA reported, she was gone, her lips were blue. During an interview on [DATE] at 11:45 AM, CNA SS reported that Resident #42 had her oxygen on more towards the morning, but the nurse did not say anything about keeping an eye on the resident. She reported her first observation of oxygen use was around 3:00 AM and that the resident was awake all night. She stated that she had not checked the oxygen saturation for the nurse and had not been asked to do anything extra. Review of the death certificate reflected that Resident #42 died from natural causes and that an autopsy was not performed. The causes of death were listed as cardiorespiratory arrest, [MEDICAL CONDITION], hypertension and diabetes mellitus. Resident #53 Review of the facility Face Sheet, dated [DATE], reflected that Resident #53 was an [AGE] year old female, re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of an incident report by LPN S on [DATE] reflected that Resident #53 was observed lying on the floor between her bed and nightstand. The resident had reported that she was reaching for her phone, which was on the nightstand. The resident had bleeding over her right eye and was sent to the hospital for evaluation. Review of a progress note by LPN S on [DATE] at 10:11 PM reflected that the resident was observed on the floor at 5:10 PM. The note reflected vital signs had been taken but did not reflect that a complete neurological assessment had been performed. Record review for a CT scan of the head reflected that on [DATE] at 7:27 PM, a small left-sided subdural hematoma (a pool of blood between the brain and its outermost covering and is most often the result of a severe head injury) measuring up to 8 millimeters (mm) in thickness with approximately 2 to 3 mm of rightward midline shift was identified. Record review of a Post-Acute Care (NAME)sfer Form for [DATE] at 6:10 PM reflected a primary visit [DIAGNOSES REDACTED]. Review of a progress note by LPN NN on [DATE] at 7:13 PM, reflected that the resident had returned from the hospital with 7 stitches and a right sided black eye. A progress note by LPN MM on [DATE] at 1:50 PM reflected that the resident had a laceration by the right eyebrow, bruising around the right eye and was not able to fully open her right eye. The note reflected that the resident continued on fall precautions and neurological checks. A progress note by LPN BBB on [DATE] at 6:36 AM reflected that the neurological assessment was within normal limits. A progress note by LPN MM on [DATE] at 1:54 PM reflected that the resident continued on fall precautions and neurological checks. A progress note by LPN S on [DATE] at 12:48 PM reflected that the resident continued to complain of a headache. There was no double vision, blurred vision or nausea. A progress note by LPN S on [DATE] at 2:21 PM reflected that the resident complained of a headache after third shift had given Tylenol. On first shift she had complained of feeling dizzy and lightheaded with the headache. There was no nausea, blurred vision or double vision. A progress note by LPN S on [DATE] at 11:00 AM reflected that (Name of Physician's group) requested that the resident was sent to the emergency room for evaluation of a recent subdural hematoma. Record review of an After Visit Summary, dated [DATE], reflected that the reason for the visit was Altered Level of Consciousness. Review of progress notes for [DATE] through [DATE] did not reflect that complete neurological checks were performed on the resident. A neurological check flow sheet was not found in the medical record. During an interview on [DATE] at 2:19 PM, Director of Nursing (DON) B reported that there were no neurological checks for the fall that Resident #53 had on [DATE]. She reported if there was an unwitnessed fall, neurological checks had to be initiated. Record review of the facility document titled, .Neurological (NAME)luation Flow Sheet reflected, .Directions: Complete neurological evaluation with vital signs initially, then every 30 minutes x 4, then every hour x 4, then every 8 hours x 9 (72 hours). More frequent monitoring may be necessary .Complete episodic charting for at least 72 hours including any pertinent evaluation findings related to the neurological evaluation. Review the most recent evaluation on the medical record and notify the physician of any changes from previous evaluation . The Neurological (NAME)luation Flow Sheet included assessment areas of, Level of Consciousness .Orientation (orientation to person, place, situation) .Pupils (pupil size of both eyes and reaction) .Motor Movement (NAME)luation (extremity movement and facial symmetry) .Communication/(NAME)uage .Unusual/New Observations (such as weakness, dizziness, headache and vision changes) .Vital Signs . Resident #15 According to a facility face sheet dated [DATE] at 4:11 PM, Resident #15 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Fall #2 [DATE] Review of a facility investigation for Resident #15, a document titled Incident Report - Patient Involved dated [DATE] at 8:30 PM (same time of day as fall #1) reflected, CNA transferring patient in sit to stand (mechanical lift) machine from shower chair to bed. Patient observed slowing letting go of handles and sliding down to floor. CNA and nurse lowered patient to the floor. Patient unresponsive for a few seconds and could not say where she was at or how she got to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 12) floor. This document reflected, Corrective Action: Sent out to the emergency room for further evaluation. On [DATE] at 09:37 AM during an interview with Unit Manager (UM) CC she was asked if Resident #15 had any syncopal ([MEDICAL CONDITION] or dizziness) episodes before the fall from the sit to stand mechanical lift. UM CC confirmed that Resident #15 had a few low blood pressures (B/P) before that fall on [DATE]. UM CC was asked if any serial orthostatic blood pressures (lying, sitting, standing blood pressures to detect a change) done. UM CC stated, No. No previous [MEDICAL CONDITION] before that episode on [DATE]. UM CC stated Resident #15 was hanging in the sit to stand lift sling and the nurse and CNA unhooked the sling and lowered her to the floor. UM CC stated this was from her interviews with the two staff members. The nurse took vital signs, assessed Resident #15, called the physician and received an order to have go to the emergency room . UM CC was asked if there was any injury and she replied that per Resident #15's progress notes, septic UTI and bilateral clavicle fractures. Resident #15 returned on [DATE]. UM CC stated that [MEDICATION NAME] (a medication that is used to treat low blood pressure or [MEDICAL CONDITION]. It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten. As a result, blood pressure is increased. https://www.mayoclinic.org/drugs-supplements/[MEDICATION NAME]-oral-route/description/drg- 821) was started on [DATE] and increased on [DATE]. On [DATE] [MEDICATION NAME] (a hypertension/heart medication) was discontinued. Orthostatic B/P's were to be done for 3 days in September, 2017. Review of the blood pressures in the EMR did not reflect any or orthostatic blood pressures or under vital signs or in progress notes per UM CC. UM CC reviewed the MAR (medication administration record) and there was a check that orthostatic B/P's were done on, ,[DATE], ,[DATE] and [DATE] but not documented on the MAR (medication administration record). No documentation of orthostatic blood pressures were found by UM CC. UM CC stated she was not sure if Resident #15 was having problems with dizziness. The facility failed to assess Resident #15's orthostatic blood pressures as ordered in [DATE] and as an assessment to determine if orthostatic [MEDICAL CONDITION] was occurring for safety with transfers. Review of facility documents for Resident #15 titled, [MEDICAL TREATMENT] Communication Form reflected that the Section 1 Completed by (Name of Facility Staff) (Send with patient to [MEDICAL TREATMENT] center) was not completely filled out to inform the [MEDICAL TREATMENT] center of any changes with Resident #15 regarding vital signs, access site, patient status, lab tests, change in diet order, current medication changes or an significant changes. Review of these sheets: [DATE] There was no documentation regarding pressure areas/wounds, [MEDICAL TREATMENT] and patient status. [DATE] There was no vital signs, [MEDICAL TREATMENT] assessment documented or pressure areas/wounds or nurse signature [DATE] There was no documentation on pressure area/wounds, significant changes, [MEDICAL TREATMENT], patient status or nurse signature. [DATE] There was no documentation regarding wounds/pressure areas, [MEDICAL TREATMENT] [DATE] There was no documentation regarding pressure areas/wounds, [MEDICAL TREATMENT] or nurse signature [DATE] A handwritten notation on the side of the facility assessment, Section 1, Please fill out. There was no documentation about wounds/pressure areas, significant change, vital signs, [MEDICAL TREATMENT], patient status, labs, diet, current medications or nurse signature. All fields in section 1 was blank. [DATE] There is no documentation regarding wounds or pressure areas or [MEDICAL TREATMENT] [DATE] There is no documentation regarding wounds or pressure areas or [MEDICAL TREATMENT] [DATE] There is no documentation regarding wounds or pressure areas, [MEDICAL TREATMENT] site and the form is not signed by a nurse [DATE] There is no documentation regarding wounds or pressure areas, [MEDICAL TREATMENT] site or patient status [DATE] There is no documentation regarding wounds or pressure areas or [MEDICAL TREATMENT] site [DATE] There is no documentation regarding wounds or pressure areas, vital signs, [MEDICAL TREATMENT], or nurse signature [DATE] There is no documentation regarding wounds or pressure area, vital signs, [MEDICAL TREATMENT], patient status or nurses signature. These documents were the only documents provided when the facility was asked for communications with Resident #15's [MEDICAL TREATMENT] unit. A pre [MEDICAL TREATMENT] nursing assessment should consist of, Assess vital signs, including orthostatic blood pressures (lying, sitting, and standing), apical pulse, respirations, and lung sounds. These data provide baseline information to help evaluate the effects of [MEDICAL TREATMENT]. Hypertension may indicate excess fluid volume. The client who is hypotensive may not tolerate rapid fluid volume changes during [MEDICAL TREATMENT]. Abnormal heart sounds (e.g., a gallop or murmur) and changes in heart rate or rhythm may indicate excess fluid volume or electrolyte imbalance. Fluid overload may also cause dyspnea, tachypnea, and rales or crackles in the lungs. Record weight. Weight changes are an effective indicator of fluid volume. Assess vascular access site for a palpable pulsation or vibration and an audible bruit and for inflammation. Infection and thrombus formation are the most common problems affecting the access site in [MEDICAL TREATMENT] clients. (http://wps.prenhall.com/wps/media/objects/,[DATE]/[MEDICAL TREATMENT].pdf) According to skin progress notes dated [DATE] at 7:45 AM, Resident #15 began to have an area from her right leg prosthesis, Traumatic dermal hemorrhage right medial (middle) mid buttock obliquely (slanting) measures 2.0 cm (centimeters) by 1.3 cm. Area fairly well defined except for interior (inside) and lateral (sideways) where there is moderate dusky red color. Otherwise very dark red blood in skin with blanching or refill. Peri wound very irregular and somewhat poorly defined measures 6.5 cm by 5.0 cm. and pale/mod pink with good blanch and measures 3.2 cm by 0.4 cm . According to skin progress notes (IDT or interdisciplinary team) dated [DATE] at 11:24 AM, Right medial mid buttock assessed. Mild serosanguinous (serum and blood) spotting noted. No debris but mild bleeding with swabbing. Area measures 1.2 cm by 1.4 cm. 70 % (percent) pale yellow necrotic dermis (dead skin) and 20 % red dermis. Skin split noted over mid coccyx level midline crease measures 0.4 cm by 0.1 cm with surrounding pale pink scaring. No significant depth. Wound bed with pale pink dermis. Per wound for both pink/violet with good blanch and refill except for area to left which is irregular old blood in skin 2.5 cm by 2.0 cm. Minimal discomfort. New area to right medial inguinal crease which obliquely measures 0.3 cm by 0.2 cm by 0.3 cm with mild bleeding. Undermining from 9:00 to 12:00 (o'clock) up to 1.0 cm at 10:00 (o'clock). Peri wound pale dusky violet due to sub Q bleeding and obliquely measures 1.5 cm by 1.0 cm. Area with no blanch and refill. [DIAGNOSES REDACTED]. Also has area to right posterior medial upper thigh. Traumatic dermal hemorrhage. Area very irregular up to 0.7 cm by 7.6 cm. Area not open but wound moderate red blood in skin from stump shrinker. Therapy notified (Name of rehabilitation center) related to skin alterations secondary to stump shrinker. Resident #15 had wounds from her prosthesis, stump shrinker and then a stage 2 pressure area to her coccyx area. Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. When this happens, a pressure ulcer may form. (https://medlineplus.gov/ency/patientinstructions/ 7.htm) There was no communication regarding Resident #15's wounds or pressure area so that bleeding may be monitored for (Resident #15 was on a blood thinner), or measures could be taken in the [MEDICAL TREATMENT] chair to relieve pressure like a pressure reducing pillow and/or frequent repositioning. Resident #38 According to a facility face sheet dated [DATE] at 1:32 PM, Resident #38 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Fall #1 [DATE], no time noted Review of progress notes dated [DATE] at 11:28 AM reflected, Patient Safety Note Text: IDT note post fall on [DATE]. Patient explains she was attempting to get out of bed and bend to pick something up at the same time. She denies injury and could verbalize how to remain safe such as, wearing grippy socks, not trying to do two things at a time, using reacher for items on floor, asking for help when needed. Fall #2 [DATE] at 6:30 AM Review of a facility investigation for Resident #38, a document titled Incident Report - Patient Involved dated [DATE] at 6:30 AM reflected, Heard yelling for help, upon entering the room, the resident (#38) stated she fell ing trying to get her drink. Drink was on the tray table at upper right side of bed. Resident states severe pain in right shoulder and she states hitting her head on the floor, so did not move resident from position .send to hospital for evaluation. This was the only Incident document provided when Incident/Accident forms for falls were requested from UM CC. Review of another progress note for Resident #38 reflected, [DATE] at 3:58 PM Patient Safety Note Text: IDT post fall review for fall on [DATE]: resident was ambulating in her room without walker. She reports reaching to put her water down and fell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 13) forward, hitting her head and hurting her right shoulder. Witness to the fall reports that she was reaching to either grab or put something down and she fell forward. Resident was sent out to the ED and returned to the facility with dx with a fracture of right clavical and urinary tract infection and started on antibiotics. BIMS (Brief interview for mental status) 11 (indicating Resident #38 is cognitively intact). She was educated by DOR regarding asking for assistance with transfers/care needs. Nurse was updated with her change in care plan. New Intervention: PT/OT (physical therapy/occupational therapy) to eval(uate) and treat, education to patient and staff, U/A (urinalysis if not completed by hospital), medication review by IPC (Neudexta, an antipsychotic medication was discontinued). Care reviewed and updated. (NAME)sfer status changed to 1 assist with gait with transfers and w/c (wheelchair) for transportation until therapy assesses. Resident #38 experienced a fall on [DATE] and [DATE]. Review of a facility document for Resident #38 titled, Neurological (NAME)luation Flow Sheet dated started on ,[DATE] (no year written) at 12:45 PM. This form reflected, Complete Neurological evaluation with vital signs initially, then every 30 x (times) 4, then every 4 hours x 4, then every 8 hours x 9 (72 hours) . This form was completed for the first 30 x 4. The next every 4 hours x 4 was not completed. This form documentation last notation is [DATE] at 8:30 PM. 72 hours from the first assessment is [DATE] at 12:45 PM. Neurological assessment were not done per facility policy. Resident #15 also fell again on [DATE] at 6:30 AM. This neurological assessment should have started over and neurological assessments be done again for another 72 hours until [DATE] at 6:30 AM. Per the Falls/Fall Risk Process Guidelines (MDCH, 2001) residents who have fallen are at risk for delayed consequences which may occur within several days after the fall; occasionally they can occur several weeks later. Acute subdural hematomas (bleeding under the covering of the brain) develop within 48 hours of injury and have an organized clot. Subacute subdural hematomas develop within 3 days to 2 weeks after a head injury. The chronic subdural hematoma can produce symptoms from about 3 weeks to several months after the injury. The damaged area is filled with fluid rather than an organized clot. (Phipps, W. J., (NAME)han, F. D., Sands, J. K., Marek, J. F., & Neighbors, M. (2003) Medical-Surgical Nursing Health and Illness Perspectives (7th ed.). St. (NAME): Mosby.) The medical record is a legal document and is used to protect the patient as well as the professional practice of those in healthcare. Documentation of the care you give is proof of the care you provide .Charting is objective, not subjective. This means chart only what you see, hear, feel, measure, and count - not what you infer or assume. All nurses know that if it wasn't charted, it wasn't done the patient's complete and accurate medical record the most reliable source of information on the care of that patient. Proper nursing documentation prevents errors and facilitates continuity of care. https://www.asrn.org/journal-chronicle-nursing/341-charting-and-documentation.html Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track (resident) outcomes, and reflect current st (TRUNCATED)
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to perform clean dressing changes, hand hygiene and assess for protein needs to heal pressure ulcers for one resident (Resident #44), out of 3 residents reviewed for pressure ulcers, from a total sample of 28 residents, resulting in an infection of a wound and underlying boney structures and the potential for slow healing wounds and further skin breakdown. Findings include: According to a facility face sheet dated 2/8/18 at 10:56 AM, Resident #44 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. According to a document titled Medication Review Report dated 2/2/18 for Resident #44 reflected, Stage 4 ulcer to left ischium .Stage 4 ulcer to sacrum . A Stage 4 Pressure Injury: Full-thickness skin and tissue loss full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) During an observation of Resident #44's wound care on 02/07/18 01:34 PM it was observed that Certified Nurse's Aide (CNA) O donned gloves and emptied the Foley indwelling catheter bag (drains urine from the bladder) of a clear yellow urine into a graduated container. No cleansing with alcohol was noted of the Foley drainage spout. CNA O then with her dirty gloved hand, was observed to pull at the top of the dressing cart to move it to the side to be able to walk by it to the bathroom. Clean dressing supplies were observed on top of this cart, no barrier was observed under the clean dressings. No preparation of the top of the cart such as disinfection was observed. Resident #44 was positioned lying in bed on her right side and 2 pressure wounds were observed, one under left buttock and one at the sacrum. Resident #44 stated she was admitted with the wounds. Resident had a bowel movement, and this was cleansed by the CNA's with adult disposable wipes and removed with the brief. No barrier observed placed under Resident #44 on bed after cleansing of the bowel movement by CNA O. LPN X donned gloves washed the wounds with a saline squirt (a single use small saline plastic container) and gauze. The buttock wound was observed to be washed from the outside skin into the base of the wound (dirty skin to clean base of the wound). Dirty dressing supplies were discarded open trash bag on the bed. LPN X was observed to prop up the saline squirt on an item in the dirty garbage bag so that the spout wouldn't leak saline. LPN X removed her gloves and was observed to cut the calcium alginate dressing needed. This cut piece was placed on top of the open dressing sleeve. LPN X was not observed to perform hand hygiene after removing her gloves. Alcohol hand gel was observed on top of the dressing cart. LPN X applied clean gloves. No hand hygiene was observed before donning new gloves. LPN X pulled out packing gauze from a container, applied saline to the gauze and placed in the lower left buttock wound. LPN X was then observed to cut the packing gauze with her scissors near the residents body after it had been packed in the resident's wound and then pulled more packing gauze from a new vial and cut this with her used scissors. LPN X was not observed to have cleaned her scissors before cutting a clean piece of packing gauze. LPN X was observed to have applied dermaskin (a skin protectant) spray to peri (around) wound AND wound packing areas then applied an occlusive foam dressing to the buttock wound. LPN X then discarded her used gloves into the garbage bag and was observed to use alcohol hand gel and applied clean gloves. The sacral wound was then observed cleansed by LPN X with the use of the propped up saline squirt applied to gauze (with clean gloves on). Again LPN X cleansed from the outside skin to the inner wound, from outside of wound in. LPN X took off her dirty gloves and applied new gloves, no hand hygiene observed. LPN X cut a calcium alginate piece with the uncleansed scissors and applied it to the wound bed. This sacral wound was observed sprayed with dermaskin around the wound AND over the wounds calcium alginate. LPN X then took off gloves and no hand hygiene observed, applied new gloves and applied foam dressing over the sacral wound. No dates were observed to be placed on either ischial or sacral wound dressings. CNA O was then observed to remove the garbage bag with gloved hands from the bed. No hand hygiene was observed after removal of CNA O's gloves. CNA O asked LPN X if the calcium alginate needed to be saved. LPN X replied, Yes, it's expensive and CNA O was observed to place the dressing with her ungloved and un cleansed hands into the original open package and placed the dressing in the dressing cart. CNA O was observed to have pulled the dressing cart out of the room and into the hall. Review of a facility policy titled, Skin Practice Guide dated issued 1/2013 reflected, Wound Management: .Dressing changes are performed using a non-sterile, clean technique unless otherwise ordered by the attending physician. In general, the following guidelines are considered when performing treatments: adhere to principles of infection control - separate clean and dirty, provide a barrier filed for treatment supplies, appropriate use and changing of gloves, maintain appropriate precautions, appropriate cleaning of the wound bed (center of wound to outside perimeter), cleansing of scissors, hand washing, disposal of soiled dressings .Dressings are dated and initialed. Review of a facility policy titled, Dressing (NAME)e: Non sterile (Clean) dated revised 4/2016 reflected, .Perform hand hygiene (each time you are entering or leaving a room and when you are going form dirty to clean) .Set up area: disinfect over bed table using an EPA approved disinfectant. While over bed table (surface) is drying, gather supplies and bring them to the patients room .perform hand hygiene upon entering. Place a clean barrier on the over bed table (surface) then place hand sanitizer, equipment and supplies on top of barrier. Do no open supplies at this point. Place waste receptacle, with leak proof bag under the over bed table .Perform hand hygiene Place procedure towel (wound drape) or clean towel under the area for treatment. Perform hand hygiene and apply latex free non-sterile drugs. Remove soiled dressing and discard in trash bag .Remove soiled gloves, discard and perform hand hygiene. Prepare a clean filed: arrange supplies on table, open packages to reveal supplies, if dressing need to be cut to size, use cleans scissors (disinfect the scissors with an EPA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 14) approved disinfectant before and after using), label tape used to secure dressing with caregiver initials and date. Perform hand hygiene and apply latex free non sterile gloves. Cleanse wound per physician's orders [REDACTED]. Clean wound then peri wound. Removed soiled gloves, discard. Perform hand hygiene and apply latex free non sterile gloves. Apply dressing per physician's orders [REDACTED]. Remove procedure towel from under patient and discard. Dispose of soiled and used disposable equipment and supplies in waste bag. Remove soiled gloves and discard. Perform hand hygiene .Return equipment and used supplies to designated area. Clean, sanitize, disinfect or dispose as indicated. Perform hand hygiene after disposing waste and or cleaning equipment. Review of a facility policy titled, Hand Hygiene dated 12/2009 reflected, Purpose: To decrease spread of infection .When to wash hands or use hand rub: before applying and after removing gloves .after contact with body fluids or excretions. Mucous membranes, non-intact skin and wound dressings if hands are not visibly soiled .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient . During an Infection Control interview on 02/07/18 at 02:10 PM with DON B, Corporate Quality Assurance (CQA) Y and Unit Manager (UM) CC, DON B stated she has been DON at the facility for a little over a week. DON B has had formal training on Infection Control facility surveillance. It was asked if hand hygiene audits have been done. UM CC confirmed she has watched handwashing but does not have documentation of who she watched, when or if any follow up training was required. UM CC and DON BB was asked about dressing change procedure and hand hygiene. DON B stated hand hygiene needs to be done before and after donning your gloves, remove dressing you wash your hands. Scissors are to be cleansed before and after each use. Dressings that are open and cut are considered used and need to be thrown away. A barrier needed to be on top of cart, under the dressing supplies. All three confirmed that propping saline squirts inside dirty garbage bag on bed was not a good infection control practice. UM CC stated that the Foley spout needed to be cleansed with alcohol before emptying, and touching the clean dressing cart touch with dirty gloves should not have occurred. On 02/07/18 at 03:49 PM during a review of medical records the records reflected, OSTEO[DIAGNOSES REDACTED] OF VERTEBRA (back bones), SACRAL AND SACR[NAME][NAME]CYGEAL REGION (lower back and tail bone area, where Resident #44 pressure ulcer is located) 12/8/2017. [DIAGNOSES REDACTED] (is): Inflammation of the bone due to infection . Both the bone and the bone marrow may be infected. Symptoms include deep pain and muscle spasms in the area of inflammation, as well as fever. Treatment includes bed rest, use of antibiotics, and sometimes surgery to remove dead bone tissue. (https://www.medicinenet.com/script/main/art.asp?articlekey=4681) Review of a document for Resident 344 titled, EMAR (electronic medication administration record) dated 10/1 to 10/31/17 reflected, [MEDICATION NAME] Capsule (an antibiotic). Give 100 mg (milligrams) via G (gastric) tube every 12 hours for [MEDICAL CONDITION] (wound) for 20 administrations) on 10/18/17 and changed on 10/19/17 to [MEDICATION NAME] Mono (an antibiotic) 100 mg cap Give 100 mg via G tube every 12 hours for [MEDICAL CONDITION] for 20 administrations. On 02/08/18 11:40 AM during an interview with Director of Nursing (DON) B, DON B confirmed there were no blood protein levels (indicates level of protein in the body so that the body can heal properly) that have been checked since Resident #44's admission.(NAME)stated she, has been doing her job long enough to know that a protein level would be warranted. An acute care document titled, Comprehensive Metabolic Panel dated 6/16/17 reflected, [MEDICATION NAME] 3.1 g/dl (grams per deciliter which is low. (NAME)l is 3.5 to 5.7 g/dl). Resident #44 has the [DIAGNOSES REDACTED]. Review of a facility policy titled, Skin Practice Guide dated issued 1/2013 reflected, Tests: .Laboratory tests including hematocrit (number of red blood cells in relation to the blood sample), hemoglobin (red blood cells carrying oxygen), [MEDICATION NAME] (protein level), hemoglobin A1C (history by blood of what glucose levels have been) and coagulation studies (how well a residents blood clots) .Phase 3: Implement .Protein: Increased protein intake is often emphasized in patients with non-healing wounds. Provide adequate protein for positive nitrogen balance, 1.25 to 1.5 gm (grams)/kg (per kilogram) body weight is recommended for nutritionally compromised patients. Reassess protein needs as condition changes and adjust for formula based on renal and liver function . Review of a document titled, Medication Review Report dated 2/2/18 for Resident #44 reflected, ProMod Liquid (Nutritional Supplement which provides 100 Calories and 10 grams of protein per ounce or 30 ml) Give 30 ml (milliliters) via PEG (stomach feeding tube) tube three times a day for wound healing. This intervention was dated as ordered 12/28/17, over 5 months after Resident #44's admission with two stage 4 pressure ulcers. Good nutritional status is essential for wound healing to take place. Ignoring nutritional status may compromise the patient's ability to heal and subsequently prolong the stages of wound healing. Glucose provides the body with its power source for wound healing and this give energy for angiogenesis and the deposition of new tissue. Therefore, it is vital that the body receives adequate amounts of glucose to provide additional energy for wound healing. Fatty acids are essential for cell structure and have an important role in the [MEDICAL CONDITION] process. Wound healing is dependent on good nutrition and the presence of suitable polyunsaturated fatty acids in the diet. Protein deficiency has been demonstrated to contribute to poor healing rates with reduced collagen formation and wound dehiscence (re opening of a wound). High exudate (a mass of cells and fluid that has seeped out of blood vessels especially in inflammation) loss can result in a deficit of as much as 100g of protein in one day. This subsequently needs to be replaced with a high protein diet. Vitamins are also important in wound healing. Vitamin C deficiency contributes to fragile granulation tissue. There is a correlation between low serum [MEDICATION NAME] and body mass index (BMI) and the development of pressure ulcers. Also, low serum [MEDICATION NAME] and high Waterlow (a scale used to assess pressure ulcer risk) score have a positive association. (https://www.ncbi.nlm.nih.gov/pubmed/ 399) The recommended amount of 0.8 g protein/kg body weight is based on the needs of healthy adults. Elderly patients may require a higher baseline protein intake of 1 g/kg. (NAME)ver, many patients, including those with wounds, don't fall into the healthy adult category and have even higher protein needs. It's known that adequate protein is crucial for proper wound healing, but the precise amount isn't established .For patients with pressure ulcers, the recommendation is also 1 to 1.5 g/kg; those with deep ulcers or multiple pressure-ulcer sites may need 1.5 to 2 g/kg .When determining the protein needs of a wound patient, it's necessary to consider additional factors, such as preexisting protein-energy malnutrition, renal impairment, or other critical illnesses. The best strategy is to evaluate the patient as a whole and use clinical judgment based on: o a physical examination for signs of catabolism (degradative metabolism involving the release of energy and resulting in the breakdown of complex materials (such as proteins or lipids) within the organism according to Merriam-(NAME) Dictionary) o a dietary history to determine typical protein intake (Resident #44 was receiving a gastric tube feedings) o a weight history to find out if unintended weight loss has occurred o laboratory values, such as serum [MEDICATION NAME], to identify catabolism and inflammation. It's also necessary to consider the depth and total body surface areas of the patient's wounds. (https://woundcareadvisor.com/how-dietary-protein-intake-promotes-wound-healing-vol2-no6/)
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** Based on observation, interview and record review, the facility failed to supervise and failed to perform a safe sit to stand mechanical lift transfer for one resident (Resident #15), out of 7 residents reviewed for falls, from a total sample of 28 residents, resulting in two falls with fractures. Findings include: Resident #15 According to a facility face sheet dated 2/8/18 at 4:11 PM, Resident #15 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Fall #1 - 11/8/17 Review of a facility investigation for Resident #15, a document titled Incident Report - Patient Involved dated 11/8/17 at 8:30 PM reflected, Resident (#15) was witnessed sitting on the floor in her bathroom. She stated she was trying to get up and fell . Prior to the incident resident was asked if she was ready for bed, she said no. When Certified Nurse's Aide (CNA) went to get her ready she put her in the bathroom, and told her (Resident #15) to call when she was done, but instead

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 15) of resident putting on the call light when she was done, she tried to stand up on her own and fell on buttocks, skin tear on left elbow when checked her vitals (vital signs) B/P (blood pressure) was 69/40 (low). Resident was responding but couldn't hold herself up and keep conversation. She was very lethargic and she (Resident #15) as leaning to the right side. Physician notified. Orders received to send to ER (emergency room) for evaluation. Review of a document for Resident #15 titled, [MEDICAL TREATMENT] Communication Form dated 11/6/17 (no time noted) reflected, Completed by [MEDICAL TREATMENT] center: .B/P 77/41, pulse 79 (pre [MEDICAL TREATMENT]) .B/P 93/38, pulse 53 (post [MEDICAL TREATMENT]). Low blood pressure, also called [MEDICAL CONDITION], is blood pressure low enough that the flow of blood to the organs of the body is inadequate and symptoms and/or signs of low blood flow develop shock. Low pressure alone, without symptoms or signs, usually is not unhealthy. The symptoms of low blood pressure include lightheadedness, dizziness, and [MEDICAL CONDITION]. These symptoms are most prominent when individuals go from the lying or sitting position to the standing position (orthostatic [MEDICAL CONDITION]). Low blood pressure that causes an inadequate flow of blood to the body's organs can cause [MEDICAL CONDITIONS], and kidney failure. It's most severe form is shock . The range of systolic blood pressure for most healthy adults falls between 90 and 120 millimeters of mercury (mm Hg). (NAME)l diastolic blood pressure ranges between 60 and 80 mm Hg (millimeters of mercury). Current guidelines define normal blood pressure range as lower than 120/80. (https://www.medicinenet.com/low_blood_pressure/article.htm) On 02/12/18 at 11:38 AM, a review of a general progress note for Resident #15 dated 11/9/2017 at 02:51 AM reflected, (NAME)ral Progress Note. Note Text: Returned from ER. Received report from nurse in ER. Stated a CT (CAT scan) of head and neck were done that were negative as well as an x-ray of pelvis and R (right) leg which were also negative. (Resident #15) Received a 500 ml (milliliter) fluid bolus (intravenously). Was answering all questions appropriately in the ER (emergency room). Resident (#15) shared with ER nurse that she had attempted to transfer herself from the toilet to her w/c by herself because she wanted the staff here at (Name of facility) to be proud of her. But that's when she fell . Returned from ER at 0200 (AM). LS CTA (lung sounds clear to auscultation) throughout. BS (bowel sounds) positive x4 (quadrants). Neuro check wnl (within normal limits). Resident (#15) very tired. C/O (complained of) R (right) leg pain. Medicated with prn (as needed) [MEDICATION NAME] (a pain medication). V.S. (vital signs) (B/P) 98/48, (Heart rate) 75, (respirations) 16, (Temperature) 97.7 , (Pulse oximetry) 97% (percent). Resident #15's blood pressure remained low even though she had received intravenous fluids in the emergency room . On 02/12/18 at 12:06 PM, review of a note dated 10/31/2017 23:21, a Medical Practitioner Note reflected, Patient seen for low bp (blood pressure) and dizziness per staff, patient is seen with dtw (daughter) present. Patient sbp (systolic blood pressure) in the 90's, patient is HD ([MEDICAL TREATMENT]) dep (dependent), denies dizziness herself, in bed, patient admits she is non-compliant with therapy recs (recommendations) with transfers . On 02/12/18 at 03:10 PM, during an interview with Director of Nursing (DON) B, if cognitive level is good to ask for assistance, they can be in the bathroom by themselves. DON B was asked even if a resident was being non-compliant with therapy recommendations, not following therapy directions and experiencing dizziness could a resident be left alone in the bathroom? DON B stated she understood the concern. According to an MDS (Minimum Data Set) quarterly assessment dated with the assessment reference date of 11/8/17, Resident #15 required a 3/3 or extensive assist of 2 to transfer from surfaces such as bed, chair or wheelchair, and 3/3 or extensive assist of 2 to toilet. Assessment Reference Date (ARD) refers to the last day of the observation (or look back) period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7 day look back period, according to the (NAME)g Term Care Facility Resident Assessment Interment 3.0 User's Manual version 1.14, October 2016. The 7 days preceding a fall in the bathroom on 11/8/17, Resident #15 required extensive assist of 2 persons to transfer and to toilet. This MDS assessment also reflected Resident #15 had a history of [REDACTED]. Review of a document for Resident #15 titled, Weights and Vital Signs dated printed on 2/8/18 at 8:20 AM, reflected no orthostatic blood pressures (lying, then sitting, then standing to detect orthostatic [MEDICAL CONDITION] or a drop in blood pressure with each position). On 11/4/19 at 10:21 PM, B/P was 95/38 (no notation what position this was taken in), 11/5/17 at 7:31 PM 94/46 (no notations on position), 11/8/17 (day of fall #1) at 8:54 PM 69/40 sitting right arm, 11/9/17 at 4:46 AM 98/48 (no notation on what position), 11/10/17 at 4:14 AM 93/46 (no notation on what position). Fall #2 11/23/17 Review of a document for Resident #15 titled, [MEDICAL TREATMENT] Communication Form the day before the second fall dated 11/22/17 (no time noted) reflected, Completed by [MEDICAL TREATMENT] center: .B/P 101/52, (no heart rate was noted) Pre [MEDICAL TREATMENT]. Vitals signs Post [MEDICAL TREATMENT] B/P 98/43, heart rate 92. The communication for the [MEDICAL TREATMENT] unit was that Resident #15 was experiencing low blood pressure after [MEDICAL TREATMENT]. Review of a facility investigation for Resident #15, a document titled Incident Report - Patient Involved dated 11/23/17 at 8:30 PM (same time of day as fall #1) reflected, CNA transferring patient in sit to stand (mechanical lift) machine from shower chair to bed. Patient observed slowing letting go of handles and sliding down to floor. CNA and nurse lowered patient to the floor. Patient unresponsive for a few seconds and could not say where she was at or how she got to the floor. Review of a handwritten document in the facility investigation, no date noted, no signature of writer reflected, 12/1(17) [MEDICAL TREATMENT] calls said then sent her out to hospital alter(ered) mental status. 12/5 Arrived AMR .purple bruising under bilateral breast and arms. 12/6(17) NP noted she spoke with hospital and that Pt. had not experienced a traumatic injury here at CV (Crestview) (even though she had on 11/9 (17), fall in bathroom that was not noted on this handwritten note). 12/3(17) Final Report: Hospital. Last admit found to have right clavicular fx (fracture) and left scapular fracture. On this visit found to have asymptomatic pelvis fractures likely due to initial fall. Some ecchymosis on right arm/axillary present prior. Right clavicular fracture/L(eft) scapular fracture due to traumatic pelvic fracture due to fall PTA with likely underlying [MEDICAL CONDITION] metabolic bone disease. [MEDICAL CONDITION], Vit D : Chronic [MEDICAL TREATMENT] related? 12/8(17) Mobile X (a mobile xray company). On 02/08/18 at 12:05 PM, Review of another hand written note in the facility investigation, no date noted, no signature noted, reflected, 11/23(17) After shower CNA at back to bed with stand up lift, CNA and nurse lowered to floor after she began to slip off lift and let go of handles. Pt. unresponsive for short time. 11/23(17) AMR (ambulance service), hypotensive. 11/24(17) (Name of acute care hospital) calls (Resident #15 is) hypoxic (poor oxygenation). 11/29(17) ED (Emergency Department) Report to ICU (Intensive Care Unit) increased WBC (white blood cells), purulent urine (pus in urine) (did not fall). Next progress note in center is 11/30/17 admitted septic UTI (urinary tract infection). 11/30(17) Now Hoyer transfer (total mechanical lift). 11/28(17) Right shoulder mildly displaced mid shaft, R(ight) clavicle fracture. 11/28 there is suggestion of a possible non displaced fracture though scapula glenoid suggestion of rotator cuff disease. pain/trauma. 11/28(17) fell on shoulder 6 days ago. Review of a radiology report for Resident #15 dated 12/8/17 reflected, Clavicle complete right Conclusion: Mid clavicular fracture (collar bone) as described .Pelvis complete minimum 3 views Conclusion: .no pelvic or [MEDICAL CONDITION]. Shoulder Complete, minimum 2 views .Conclusion: .no acute fracture. Review of an acute care hospital document for Resident #15 titled, Patient Discharge Instructions dated 11/30/17 at 1:53 PM reflected, Updated Medications: .[MEDICATION NAME] 3 mg (milligrams) 1 tab by mouth daily. [MEDICATION NAME] or [MEDICATION NAME] is a blood thinner. On 02/12/18 at 12:14 PM, during a phone interview with Licensed Practical Nurse (LPN) JJ she stated she remembers the incident on 11/23/17 with Resident #15. I was in the room with her neighbor (roommate). The CNA was putting resident to bed after a shower. The CNA asked me when Resident (#15) up in sling, look at her bottom, as I went to look, she (Resident #15) began to slide. We tried to get her to bed. Bottom went to the floor, too late. Guided her down to the floor. LPN JJ stated there was no fall (a change in plane is a fall) just a lowering. LPN JJ stated Resident #15 was unresponsive, she got vital signs. LPN JJ revealed Resident #15 couldn't breathe wanted to go to sleep. Resident #15 could move her arms and legs. Resident #15 was still going in and out (of consciousness) so EMS (emergency medical services or ambulance) was called. A Hoyer mechanical lift was used to get Resident #15 from floor to bed LPN JJ stated, and Resident #15 was more coherent at that time. Resident #15 had no complaints of pain. EMS arrived in 15 to 20 minutes. During an observation of a sit to stand transfer with Resident #44 from chair to bed on 02/07/18 at 01:31 PM with CNA XX, CNA she revealed she cannot do the transfer by herself, the transfer requires two staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	**02/14/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	**625 36TH ST SW WYOMING, MI 49509**

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 0689

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 16)

Review of a facility document titled, Injury Prevention: Lifts and Injury - Reducing Devices Manual dated 9/2017 reflected, Number of employees required when operating a lift. Although one person can operate most models of hydraulic lists, it's advisable to have two staff members present to stabilize and support the patient .

Review of a document for Resident #15 titled, Weights and Vital Signs dated printed on 2/8/18 at 8:20 AM reflected no orthostatic blood pressures (lying, then sitting, then standing to detect orthostatic [MEDICAL CONDITION] or a drop in blood pressure with each position). This document reflected, 11/21/17 at 10:21 AM 97/49 (no notation on what position this was taken), 11/23/17 (day of fall #2) at 4:33 PM 95/46.

On 02/08/18 at 09:37 AM, during an interview with Administrator A, Unit Manager (UM) CC and Corporate Quality Assurance Y they were asked if Resident #15 had any syncopal ([MEDICAL CONDITION] or dizziness) episodes before the fall from the sit to stand mechanical lift. UM CC confirmed that Resident #15 had a few low blood pressures (B/P) before that fall on 11/23/17. UM CC was asked if any serial orthostatic blood pressures (lying, sitting, standing blood pressures to detect a change) done. UM CC stated, No. No previous [MEDICAL CONDITION] before that episode on 11/23/17. UM CC stated Resident #15 was hanging in the sit to stand lift sling and the nurse and CNA unhooked the sling and lowered her to the floor. UM CC stated this was from her interviews with the two staff members. The nurse took vital signs, assessed Resident #15, called the physician and received an order to have go to the emergency room . UM CC was asked if there was any injury and she replied that per Resident #15's progress notes, septic UTI and bilateral clavicle fractures. Resident #15 returned on 11/30/17. UM CC stated that [MEDICATION NAME] (a medication that is used to treat low blood pressure or [MEDICAL CONDITION]. It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten. As a result, blood pressure is increased. https://www.mayoclinic.org/drugs-supplements/[MEDICATION NAME]-oral-route/description/drg-821) was started on 11/1/17 and increased on 11/9/17. On 10/17/17 [MEDICATION NAME] (a hypertension/heart medication) was discontinued. Orthostatic B/P's were to be done for 3 days in September, 2017. Review of the blood pressures in the EMR did not reflect any or orthostatic blood pressures or under vital signs or in progress notes per UM CC. UM CC reviewed the MAR (medication administration record) and there was a check that orthostatic B/P's were done on, 9/8, 9/9 and 9/10/17 but not documented on the MAR (medication administration record). No documentation of orthostatic blood pressures were found by UM CC. UM CC stated she was not sure if Resident #15 was having problems with dizziness.

On 02/12/18 10:42 AM, during an interview with Physical Therapist (PT) LL. Resident #15 PT LL revealed that a lift assessment on 10/30/17, Resident #15 was walking with right leg prosthesis 20 feet with minimal assistance and a 2 wheeled walker. PT LL stated Resident #15 exhibited dizziness on 11/1/17 during physical therapy. On 11/1/17 PT visit note reflected that Resident #15 was having difficulties with dizziness. PT LL stated Resident #15 was unsafe, trying to get up on her own and not following directions. PT LL confirmed there was no change in transfer status at that time. Resident #15 remained a contact assist (requires a staff member to have contact with the resident) to transfer. On 11/2/17, PT LL stated therapy was working on walking with Resident #15. Resident #15 continued to have difficulties with dizziness. No mechanical lift was needed with right leg prosthesis. 11/3/17 Resident #15 was not feeling well and just sitting exercises were completed. On 11/6/17 Resident #15 continued to have dizziness and decreased safety awareness. PT LL stated Resident #15 was acting weird. I'm gonna get up anyway, Resident #15 was telling therapy. Added pressure relieving cushion to wheelchair. No lift transfers needed at this time for Resident #15. On 11/7/17, a home evaluation was completed for Resident #15. On 11/8/17 (day of fall #1 in the bathroom) Resident #15 was complaining of dizziness. Resident #15 could transfer edge of bed to wheelchair with stand by assist. PT LL stated she knew Resident #15 went to hospital but no changes related to that (for transferring/assistance/care needs). I think (Resident #15) went in by herself to toilet. Resident #15 wanted to see what she could do. PT LL confirmed that Resident #15 was not independent in the bathroom. On 11/9/17, Resident #15 required maximum need for assistance for transfers. PT LL stated Resident #15 still did not need mechanical lift transfers. On 11/14/17 Resident #15 was assessed to now need a sit to stand mechanical lift transfer with minimal assist. How many persons are needed to perform a sit to stand lift? PT LL stated, 2. PT LL stated Resident #15 could stand with minimum assist. On 11/16/17, Resident #15 was assessed to require moderate assist for transfers. On 11/21/17 during a care conference it was revealed that Resident #15 could stand with moderate assist of 1 person for 1 min.

According to a facility document titled, Patient (NAME)sfer Screen Worksheet reflected, If yes to all of the criteria, patient is a candidate for using a sit to stand mechanical transfer device with appropriate weight capacity. If NO to any of these 3 criteria, patient is a candidate for full dependent mechanical lift with appropriate weight capacity. According to PT LL, Resident #15 met all the criteria for sit to stand use however this policy also reflected, There may be instances due to a unique clinical circumstance when a patient requires a different level of assist than determined from this guidance .Or a patient's condition, ability to transfer and amount of assistance required may vary over the course of the day. It may be necessary to use a higher level of assistance at those times. Resident #15 was experiencing dizziness and the need for moderate assist for transfers on 11/16/17 according to PT LL. On 11/21/17, two days before fall #2, Resident #15 could only stand with moderate assist of 1 person for only 1 minute. The sit to stand mechanical lift manual there is an assessment titled, Lift Program Skills Check Off Sheet (NAME)d Assist Mechanical Lifts dated 9/2017. This check off reflected, Questions that need to be answered prior to using the(NAME)3000 (or sit to stand mechanical lift): Can the individual bear weight on at least one leg? . Resident #15 could only do so for 1 minute.

Review of an acute care hospital document for Resident #15 titled, Patient Discharge Instructions dated 11/30/17 at 1:53 PM reflected, Updated Medications: .[MEDICATION NAME] 3 mg (milligrams) 1 tab by mouth daily. [MEDICATION NAME] or [MEDICATION NAME] is a blood thinner. Resident #15 was taking this medication while experiencing the fall on 11/8 and 11/23/17. According the American Heart Association, [MEDICATION NAME] (brand names [MEDICATION NAME] and Jantoven) is a prescription medication used to prevent harmful blood clots from forming or growing larger. Beneficial blood clots prevent or stop bleeding, but harmful blood clots can cause a [MEDICAL CONDITION], stroke, [MEDICAL CONDITION] or [MEDICAL CONDITION] embolism. Because [MEDICATION NAME] interferes with the formation of blood clots, it is called an anticoagulant. Many people refer to anticoagulants as blood thinners; however, [MEDICATION NAME] does not thin the blood but instead causes the blood to take longer to form a clot .Some simple changes to decrease the risk of bleeding while taking [MEDICATION NAME] include the following: Use a soft-bristle toothbrush, Floss with waxed floss rather than un waxed floss, Shave with an electric razor rather than a blade, Take care when using sharp objects, such as knives and scissors, Avoid activities that have a risk of falling or injury (e.g., contact sports).

The most prevalent [MEDICAL CONDITION] in our study was a subdural hematoma. As humans age, the brain begins to atrophy and therefore the bridging veins are stretched. This makes it more likely for the bridging veins to tear during a fall as the momentum of the brain provides a shearing force within the skull. One thing that is obvious in our study is that falls from a standing height is a cause of significant morbidity and disability, especially in patients on [MEDICATION NAME]. (https://www.clinmedjournals.org/articles/ijnn/ijnn-2-023.pdf). Resident #15 was at high risk for a severe injury such as an [MEDICAL CONDITION] such as a subdural hematoma because of the prescription [MEDICATION NAME].

Review of a facility policy titled, Falls Practice Guide dated 12/2011 reflected, Initial (NAME)luation: .Medication review. Medications side effects may predispose a patient for falls for fall risk. Such medication or medication classification may include but are not limited to: anti arrhythmic, anti-[MEDICATION NAME], anti-depressants, anti-epileptics, anti-hypertensives, anti-parkinsonian, diuretics, narcotic [MEDICATION NAME], benzodiazepines, anxiolytics, [MEDICAL CONDITION]. In addition to the above medications classifications, addition medication classifications that are more commonly associated with injury from fall include anticoagulants (such as [MEDICATION NAME]) . This policy also reflected, Laboratory or diagnostic tests may assist the physicians and clinicians in determining the root cause of falls and in identifying further fall risk. These test may include, but are not limited to: blood tests .bedside tests including oxygen saturation, orthostatic blood pressures .

Review of an acute care hospital document for Resident #15 titled, Patient Discharge Instructions dated 11/30/17 at 1:53 PM reflected, Updated Medications: .[MEDICATION NAME] (an anticoagulant) 3 mg (milligrams) 1 tab by mouth daily .[MEDICATION NAME] (an anti-epileptic) 100 mg 1 capsule by mouth daily .[MEDICATION NAME] (an antiarrhythmic) 200 mg 1 tab by mouth once a day .[MEDICATION NAME] (an anti-hypertensive) 25 mg one tab by mouth daily .and [MEDICATION NAME] (classified as a narcotic in some states) 50 mg one every eight hours. Resident #15 was on 5 medications that put her at high risk for falls.

Resident #15 was deemed at risk for a fall. Resident #15 was left in the bathroom alone when she was not deemed independent in the bathroom, while having a recent problem with dizziness, low blood pressure and poor compliance with directions and experienced a fall while on a blood thinner (fall #1). Resident #15 was transferred with a sit to stand lift by one person while continuing to have dizziness, low blood pressures and the inability to stand for over 1 minute in a sit to stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 17) mechanical lift requiring the resident be able to bear weight on a leg, resulting in a fall with a fracture of her clavicle while on a blood thinner (fall #2). Review of Resident #57's face sheet dated 2/6/18, revealed Resident #57 was a [AGE] year old male admitted to the facility on [DATE] and had the following diagnose: [MEDICAL CONDITION], delusional disorders, muscle weakness, difficulty walking and lack of coordination. Resident #57 was not his own responsible party. 02/05/18 11:06 a.m. Resident 57 was observed up in a geriatric style chair (reclined chair with foot rest) in hall. Resident #57 was asked if chair was comfortable and he said no. Resident #45 could not say how long he was up or why he was uncomfortable. Resident #57 said he wanted to go to bed. Certified Nurse's Aide (CNA) O was asked if Resident #45 needed to go to bed because he was uncomfortable and CNA O said, no, if he goes to bed he will stand up, walk and fall. CNA O readjusted the Geri chair to a more reclined position. 02/08/17 9:20 am. CNA O and CNA RR put Resident #57 in bed from his geriatric style chair. CNA's provided hygiene care. CNA's said Resident #57 could not stay in bed because he would get up and fall. Resident #57 was place back in his Geri Chair, in a reclined position in the hall after care. Review of Resident #57's Physical Therapy discharge note dated 6/8/17 documented Resident #57 could walk 170 feet with a 2 wheeled walker and minimal assist of one person. During an interview with the Therapy Director EE on 2/12/18 at 2:00 PM, SS confirmed Resident #57 could walk 170 feet with a 2 wheeled walker and one person assist when Physical Therapy discharged him on 6/8/17. EE could not find the standard documentation that was provided nursing with instructions to help maintain a Residents function when discharged from therapy. EE could not locate any documentation that would explain why nursing did not receive any instructions to continue to walk with Resident #57 when discharged from therapy on 6/8/17. During an interview with RN CC, Director of Nursing (DON) B and Nursing Home Administrator A on 2/12/18 at 2:00 PM Resident #57's falls from 7/6/17 to 12/1/17 were reviewed (total of 14 falls). The facility could not locate a full investigation with a root cause analysis for all 14 falls. Interventions placed did not always provide increase assistance or supervision. Two falls 8/28/17 and 12/1/17 had the same intervention (restraint) and no orders, interventions to release, prevent decline or care plan for the restraint could be located. None of the interventions included increased supervision. Review of Resident #57's Incident Report dated 8/28/17 at 12:30 PM, documented, Resident attempted to get out of his recliner then staff assisted him to the floor as resident was sliding off the recliner. Did not his head to the floor. Under corrective action documented, Staff will have name of geriatric style chair tilted back whenever resident is in name of geriatric style chair unless resident is eating or drinking (This made the geriatric style chair a restraint as evidenced by documentation that Resident #57 could get out of the chair when sitting up and stand when it was not reclined, no order for this restraint or restraint evaluation was located at this time). Review of Resident #57's Incident Report dated 12/1/17 at 7:01 PM, documented, Res (resident) at nurse's station in name of geriatric style wheel chair. Observed attempting to stand from chair, Resident's knee buckled and ended up on both knees on floor with feet in chair. Under corrective action documented, Must remain reclined between meals. (Restraining resident #57 to prevent falls, without an evaluation, orders or release times).
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to cue to eat, offer alternatives, to monitor weights at the same time daily and to monitor dietary intake to prevent weight loss for one resident (Resident #59), out of 5 residents reviewed for nutrition, from a total sample of 28 residents, resulting in weight loss. Findings include: According to a facility face sheet dated 2/8/18 at 8:28 AM, Resident #59 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. Resident #59 spoke Spanish and did not speak English well. Review of a Minimum Data Set assessment ((MDS) dated [DATE] reviewed on 02/08/18 at 10:26 AM with MDS coordinator QQ, she stated Section G for activities of daily living auto populates from certified nursing aide (CNA) documentation. Eating was reflected as 0/2 indicating Resident #59 was independent but needed assist of 1 person. MDS coordinator QQ stated the care plans were not driven by an MDS assessment but by the interdisciplinary team (IDT). During an interview through a translator and observation on 02/05/18 at 11:36 AM, Resident #59 stated doesn't like the food. Food is too soft. Resident #59 was asked if she gets choices and she stated she can get hot dogs. Resident #59 stated she doesn't like the food so she has lost weight. She stated sometimes she eats, sometimes she doesn't. Ensure plus on bed side table. Resident #59 stated she has talked to someone about food, not sure who, no one listens to her. She would like spice to her food. Resident #59 is from Mexico. Not enough flavor. She stated. On 02/06/18 at 09:37 AM, it was observed that a translator was visiting with Resident #59. A breakfast tray was observed on the bedside table. Resident #59 motioned to me to remove the tray. It was observed that 1/2 English muffin and scrambled eggs were left on her plate. Certified Nurse's Aide (CNA) R came in and spoke fluent Spanish with Resident #59. It was not observed that she cued Resident #59 to eat or offered her any alternatives to eat. On 02/07/18 at 01:07 PM, Resident #59 was observed in her room by herself. An over bed table contained a lunch tray. Resident #59 stated in Spanish too chewy Housekeeper YY, who happened to enter the room translated. Housekeeper YY stated she has had two years of Spanish. No food had been eaten from Resident #59's lunch. No translator was in room to cue Resident #59. On 02/07/18 at 01:11 PM, it was observed that CNA T went into Resident #59's room. CNA T had a brief conversation as follows, No mas? (No good) CNA T asked. CNA T was then observed to have brought the full tray of food out and no alternatives were offered by CNA T. No encouragement was observed in this brief interaction. Review of a care plan dated 9/21/15 for Resident #59 provided by (NAME)tered Dietician (RD) N as interventions to prevent weight loss reflected, Nutritional status as evidenced by potential weight loss/gain related to possible fluid fluctuations. Resident has history of significant weight loss, underweight. Dated revised on 2/2/18 by RD N. Interventions: Encourage and assist as needed to consume foods and/or supplements and fluids ordered, dated 9/21/15. Review of a facility document for Resident #59 titled, Weights and Vitals Summary reflected, 2/3/17 at 9:16 PM 120.9 lbs. (pounds) -10% (percent) change .3/1/17 at 2:07 PM 126.5 lbs .4/1/17 at 5:21 PM 122 lbs .5/2/17 at 10:05 AM 117.8 lbs .6/3/17 at 3:25 PM 116 lbs .7/4/17 at 2:31 PM 114.9 lbs .8/1/17 at 2:47 PM 110 lbs .9/1/17 at 11:43 PM 109.2 lbs .10/2/17 at 10:51 PM 112 lbs .11/13/17 at 11:59 AM 97 lbs .12/1/17 at 1:25 PM 99.2 lbs .1/1/18 at 10:47 AM 98 lbs. Each weight was completed at different times of day. When you do weigh yourself on a scale, Dawn Blatner, (NAME)tered Dietician says you strive for sameness. Weigh yourself at the: o (NAME)e time of day, on the o (NAME)e day each week, wearing the o (NAME)e clothing, and using the o (NAME)e scale. (https://www.webmd.com/diet/features/weighing-in-on-scales-find-your-true-weight#1) During an interview on 02/07/18 at 02:55 PM with (NAME)tered Dietician (RD) N, he stated he spoke a little Spanish. When asked how he assessed Resident #59's preferences he stated the last assessment, touched on it here and there when the volunteer was here. RD N stated he has talked to Resident #59's family. Resident #59 liked authentic Mexican food. He stated family was bringing some in. Resident #59 liked spicy foods. RD N confirmed that Resident #59 could have a regular diet. RD N stated Resident #59 was ill last (NAME)h 2017, and had fluid retention, lung problems. When Resident #59 returned she was on thickened liquids and a mechanical soft diet. RD N asked speech therapy to evaluate Resident #59's swallowing abilities and a month later a regular diet was restarted. RD N stated Resident #59 was eating better on a regular diet. Resident #59 loved ensure plus (a liquid diet supplement) so he wanted to get a supplement and that was not possible when Resident #59 was on a thickened liquid diet. RD N stated Resident #59 did trigger for a significant weight loss with fluid loss (from diuretics) and intake. RD N stated Resident #59 likes fried eggs, scrambled eggs, cereal. Resident #59 is on Ensure plus but no fortified foods. RD N stated he did try to add extra butter to her diet when he can. RD N stated Resident #59 could have a hot sauce. RD N stated there was a care conference regarding food. RD N stated they try and cook for her. RD N stated Resident #59 needed assistance when she was ill but she is now better. Resident #59 liked to eat with her fingers. RD N has tried serving sandwiches. Resident #59 triggered for significant weight loss [DATE]. RD N stated the texture of the mechanical soft diet was the problem so finally got swallowing study on 11/10/17. Resident #59 refused magic cup when back from hospital (thickened liquid). RD N was asked what interventions were tried after significant loss triggered. RD N stated they concentrated on what she ate and eats best at breakfast, doubled up on eggs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 18) RD N stated they have tried having Resident #59 eat with others doesn't want to. RD N was asked if anyone came to feed her or encourage her. RD N stated the volunteer was in and let him know what she ate. RD N stated no encouragement is given, Resident #59 ate at own pace, did her own thing. RD N was told of today's observation and Resident #59 was given no encouragement or alternative choice. RD N confirmed there was no care plan intervention in August to prevent more weight loss, there was no direction that if Resident #59 ate less than a certain percentage that an alternative be offered. RD N stated Resident #59 was at borderline healthy vs unhealthy with a 20.4 BMI. 111 lb. after fluid loss. Resident #59 is now 97.4 lbs. RD N stated Resident #59 was stable since November 2017. Review of a Minimum Data Set ((MDS) dated [DATE] with RD N reflected Resident #59 as, independent but assist of 1 '0/2'. Review of Resident #59's current care plan revealed Resident #59 was assist as needed. RD N stated Resident #59's calorie need was 1100 to 1300 calories needed. RD state Resident #59 is consuming 1000 calories a day RD N confirmed a food acceptance record (FAR) is being kept to monitor Resident #59's intake. RD N stated it depended on the meal, the acceptance averages 50 %. RD N stated the FAR doesn't list type of intake such as protein percentage, starch percentage, fruit and vegetables, etc. RD N stated he doesn't go on intake record to monitor intake, RD N stated he was hands on, he checked with Resident #59 daily. Review of a facility document for Resident #59 titled, P[NAME] Response History dated 1/10/18 to 2/7/18 revealed Resident #59 what she was consuming at each meal. On 2/13/18 for 2:23 PM, there was no response noted but a check mark under resident refused. Doesn't indicate if another alternative was offered. On 1/17/18, there is only a meal at 10:20 PM documented as 50% eaten. On 1/18/18 at 2:46 PM there was a check mark under resident refused but this did not indicate if an alternative was offered. On 1/23/18 at 2:13 PM there was a check mark under resident refused but no indication if an alternative was offered. This also occurred on: 1/26/18 at 7:33 PM, 1/27/18 at 8:39 PM, 2/1/18 at 6:38 PM, and 2/7/18 at 10:53 PM. These times did not indicate if it was a meal or a snack. Documentation was 3 times a day only. The current approach to assessing nutritional intake requires nursing home (NH) staff to document total percentage of food and fluid consumed at each meal. Because NH staff tend to significantly overestimate total food intake, methods need to be developed to improve the accuracy of food intake measurement. https://www.ncbi.nlm.nih.gov/pubmed/ 952 During an interview on 02/07/18 at 04:04 PM with RD N, he confirmed that Resident #59's protein and [MEDICATION NAME] levels are good. RD #59 stated that Resident #59 was not malnourished. RD N presented an order for [REDACTED]. RD N stated snacks are offered in between meals and at night and Resident #59 liked cereal in between breakfast and lunch. He state Resident #59 also liked Ensure in coffee. On 02/08/18 at 08:51 AM, Resident #59 was observed sitting at the side of the bed with over bed table in front of her. A tray with food was on this table. Resident #59 was feeding herself eggs and drinking from a plastic mug with a cover. Resident #59 was observed to have 2 mugs of hot liquids with covers, a small glass of cranberry colored liquid. No one else was observed to be in the room other than her. Review of a facility policy, No title page given, no date noted on pages 3 and 4 given, reflected, Unplanned weight loss: .Promising practices include: individualizing what works best for patients who typically under eat - either mealtime feeding assistance or between meal snacks, heightened oversight by a direct care staff with presence during mealtime, dining environment enhancements .
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to sufficiently staff the facility to meet the needs of the residents for 2 residents (Resident #4 and 45) and 4 of 13 in the confidential Resident Council meeting, resulting in unmet care needs, decreased feelings of self-worth, and lack of ability to attain and maintain the highest practicable level of wellbeing. Findings include: Confidential Resident Council Interview On 02/06/18 at 02:31 PM, a Resident Council interview of 13 Residents and 1 family member revealed, one resident stated, aides are called to assist to toilet and leave without fulfilling their needs and took an hour to come back. You're going to have to wait. One resident had been told. Four out of 13 residents agree this occurs. Four of the 13 residents have had accidents (soiling or wetting themselves) because of the time it took waiting for assistance. One resident stated aides are upset when they turn the light back on. The residents stated they felt, dirty, horrible, not respected and angry. One resident stated they put on the call light and waited 2 hours. When asked how they know it was 2 hours, they stated there is a clock next to them and they watched the time. According to a facility policy titled, Call Lights dated 12/2009 reflected, Purpose: To use a light and/or sound system to alert staff to patient needs .Answer all call lights in a prompt, calm and courteous manner. All staff regardless of assignment can answer call lights .Turn of call light - light should not be turned off until request is met. Respond to request or, if unable to do so, refer request to appropriate staff member immediately. Always position call light conveniently for use and in reach. Resident #45 Review of Resident #45's face sheet dated 2/8/18, revealed he was an [AGE] year old male admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. 02/05/18 at 09:57 a.m. Resident #45 complained of slow call light response but could not recall times or what needs were not being met, just general frustration with delays in care. On 2/6/18 at 8:41 a.m. Resident #45 was observed sitting on the edge of his bed in his room eating breakfast and put his call light on. Resident #45 placed his call light on 2 more times before he received the hot water at 9:15 a.m. Staff interviews On 2/6/18 at 9:41 am RN H was observed passing medication to Resident #32. RN H said she had to pass medications to 22 or 23 Residents every day and if frequently unable to complete the morning medication pass as order. RN H said she did not complete the 8:00 a.m. medication pass today (2/6/18) as ordered so she had to cal the doctor to obtain new orders for 8 residents. RN H said she had reported this problem to her direct supervisor on several occasions but nothing is being done. On 2/08/18 at 8:46 Licensed Practical Nurse (LPN) MM was observed passing medications to the Resident in room [ROOM NUMBER]. When LPN MM completed the electronic charting for the Resident in room [ROOM NUMBER], the computer screen identified 6 Residents as having medications passed due. LPN MM said she was not able to complete her medication pass on time today because she had to assist a resident with breakfast. LPN MM said she was going to have to call the doctor and get new orders for all six residents. LPN MM said this happens frequently. Resident #4 Review of the facility Face Sheet, dated 2/7/18, and the annual Minimum Data Set assessment (MDS) (an assessment to identify resident care needs), dated 1/17/18, reflected that Resident #4 was an [AGE] year old female, readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected that she had a Brief Interview for Mental Status assessment (BIMS) (a cognitive screening tool) of 13 out of 15, which indicated she was cognitively intact. She required one person extensive assist for bed mobility, dressing, eating, toilet use, personal hygiene and bathing. During an interview on 2/6/18 at 10:11 AM, Resident #4 reported that sometimes she waited for an hour or so for her call light to be answered. She reported that the wait for her call light to be answered was worse during mornings. On 2/6/18 at 10:38 AM, Resident #4 was observed using her call light to use the bathroom. Staff members passed by her room, without entering to address her need, until Certified Nursing Assistant (CNA) T responded at 11:17 AM (39 minutes after the resident turned her call light on). In an interview on 2/12/18 at 1:04 PM, Nursing Home Administrator (NHA) A reported that call light times were talked about in the facility Quality Assurance (QA) meeting. She reported that the concern first came to the attention of the facility around the end of December 2017 or the beginning of January 2018. NHA A reported that there were complaints on the late evening shift, so she started going to the facility periodically during the night to see how it was going. NHA A reported, we got so busy with other things that we are nowhere near fixing the problem. NHA A further stated that the complaints she was hearing were from the residents, specifically about the midnight shift. When asked if there was a goal for call light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 19) response time, NHA A reported that she was unsure if the facility had a policy for call lights. She reported that any staff passing by should have been responding to the call light to see if they could meet the need. If they could not meet the need, they should have found someone who could. The initial person to respond to the call light should have followed up to make sure the need was addressed if they were unable to personally meet the need. The facility policy titled, CALL LIGHT with a date of 12/2009 reflected, .1. Answer all call lights in a prompt, calm, courteous manner. All staff, regardless of assignment, answer call lights .5. Respond to request or, if unable to do so, refer request to appropriate staff member immediately .
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to: 1. Provide air gaps and proper backflow prevention throughout the kitchen area; 2. Ensure proper storage of raw and ready to eat food products; and 3. Ensure areas of Non-food contact surfaces were free from the accumulation of debris. These conditions resulted in an increased risk for contaminated foods and an increased risk of food borne illness that affected all 65 residents that consume food from the kitchen. Findings include: 1. During an initial tour of the kitchen starting at 9:50 AM on 2/5/18, accompanied by Food Service Director (FSD) M and Dietician N it was observed that the food preparation sink and the sanitizer compartment of the three compartment sink were directly connected to the waste water system. These sinks are required to be air gapped in order prevent the contamination of food and food contact equipment. According to the 2009 FDA Food Code section 5-202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonFOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). According to the 2009 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . It was also observed that the Janitors sink in kitchen is hooked up in a manner that puts both atmospheric vacuum breakers (AVB's) under constant back pressure. When found, the sink was observed on, with an AVB built into the faucet as well as attached to the spout of the faucet. Attached to the AVB on the spout was a Y valve that had one side going to a hose feeding water to a pressure washer and the other side going to a pre dispense chemical supply on the wall. Both AVB's are an American Society of Sanitary Engineering (ASSE) 1011 standard and are not rated for back pressure. According to the 2009 FDA Food Code section 5-202.14 Backflow Prevention Device, Design (NAME)dard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. 2. During an initial tour of the kitchen starting at 9:50 AM on 2/5/18 it was observed that a sheet pan of raw chicken was stored on top of a cart in the walk in cooler. The sheet pan was laying on a hotel pan of ready to eat coconut crunch. FSD M stated raw animal product should be stored on the bottom so that it does not contaminate other foods. FSD M also pointed out that there is a poster on the walk in cooler wall that shows how to store food product. Dietician N stated that the coconut crunch will be thrown out and remade. According to the 2009 FDA food code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: .separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, and (b) (NAME)d READY-TO-EAT FOOD . 3. During a tour of the kitchen at 9:50 AM on 2/5/17 it was observed that some areas of Non-Food contact surfaces shown accumulation of dust and food debris. These areas in particular were: The overhead spray used for filling the steam ovens which showed heavy brown crusting around the spray head, drawers in the Hydration / Pantry room were heavily soiled with brown and yellow staining and crumb debris, and the gaskets of the 3 door continental cooler showed black staining along the perimeter. According to the 2009 FDA Food Code section 4-602.13 4-602.13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on observation, interview, and record review, the facility failed to administer its policies, practices and procedures in a manner that displayed effective and efficient use of its resources to ensure the achievement and maintenance of the highest practicable physical, mental and psychosocial well-being of each resident, as evidenced by the following: 1. The facility failed to maintain the dignity of 9 residents (Resident #4, 5, 19, 28 and 45 and 4 out of 13 from the confidential group interview) out of 25 residents reviewed for dignity from a total sample of 28 residents resulting in feeling of shame, embarrassment and decreased self-worth. (See findings in F-550) 2. The facility failed to address Resident Council grievances according to 12 of 13 of the Confidential Resident Interview from a total facility census of 67 residents resulting in unresolved resident concerns, unmet care needs and decreased feelings of self-worth. (See findings at F-565) 3. The facility failed to notify the Durable Power of Attorney (DPOA) and physician of a change in condition for 1 resident (Resident #42) and failed to promptly notify the DPOA of a change in condition for 1 resident (Resident #13) of 2 reviewed for notification of change, from a total sample of 28, resulting in absence of treatment and delay of treatment. (See findings at F-580) 4. The facility failed keep one resident free from restraints and maintain physical function for one resident (Resident #57) out of 1 resident reviewed for restraints from a total sample of 28 Residents, resulting in the restraint and physical decline of Resident #57 and the potential for psychological harm. (See findings at F-604) 5. The facility failed to complete an accurate restraint assessment for one resident (Resident #57) of 1 Resident Reviewed for restraints from a total sample of 28 Residents, resulting in Resident #57 being physically restrained and declining in physical function. (See findings at F-636) 6. The facility failed to provide the care and services to prevent physical decline for 1 resident (Resident #57) out of 28 residents reviewed for care from a total sample of 28 residents, resulting in Resident #57 having an avoidable decline in walking and physical movement. (See findings at F-676) 7. The facility failed to perform complete neurological assessments after falls for 2 residents (Resident #38 and #53) and failed to appropriately assess and monitor 2 residents (Resident #15 and #42) of 28 reviewed for quality of care, from a total sample of 28, resulting in residents not receiving care and treatment in accordance with professional standards of practice and unrecognized changes in condition. (See findings in F-684) 8. The facility failed to perform clean dressing changes, hand hygiene and assess for protein needs to heal pressure ulcers for one resident (Resident #44) out of 3 residents reviewed for pressure ulcers from a total sample of 28 residents resulting in an infection of a wound and underlying bony structures and the potential for slow healing wounds and further skin breakdown. (See findings at F-686) 9. The facility failed to supervise and failed to perform a safe sit to stand mechanical lift transfer for one resident (Resident #15) out of 7 resident reviewed for falls from a total sample of 28 residents resulting in two falls with fractures. (See findings at F-689)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 20) 10. The facility failed to sufficiently staff the facility to meet the needs of the residents for 2 residents (Resident #4 and 45) and 4 of 13 in the confidential Resident Council meeting resulting in unmet care needs, decreased feelings of self-worth and lack of ability to attain and maintain the highest practicable level of wellbeing. (See findings at F-725) 11. The facility failed to: 1. Provide air gaps and proper backflow prevention throughout the kitchen area; 2. Ensure proper storage of raw and ready to eat food products; and 3. Ensure areas of Non-food contact surfaces were free from the accumulation of debris. These conditions resulted in an increased risk for contaminated foods and an increased risk of food borne illness that affected all 65 residents that consume food from the kitchen. (See findings at F-812) 12. The facility failed to identify and implement appropriate plans of action to correct quality deficiencies necessary to assure residents attain and maintain the highest practicable level of well being, resulting in the potential for serious negative physical and psychosocial outcomes for all 67 residents residing at the facility. (See findings at F-867) 13. The facility failed to maintain infection control practices to prevent infection for 4 residents (Residents #11, 28, 44 and 71) out of 25 residents reviewed for infection control practices out of a total sample of 28 residents resulting in infection of a wound and surrounding boney structures and a urinary tract infection (Resident #44) resulting in the potential for infection during a clean dressing change (Resident #71) and the potential for cross contamination from contaminated items (Residents #11 and 28). (See findings at F-880) 14. The facility failed to develop and implement comprehensive, person-centered care plans for 5 residents (Resident #4, #15, #28, #38 and #59) of 25 reviewed for comprehensive care plans, from a total sample of 28 residents, resulting in the potential for inadequate care and unmet care needs. (See findings at F-656)
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on interview and record review, the facility failed to identify and implement appropriate plans of action to correct quality deficiencies necessary to assure residents attain and maintain the highest practicable level of well being, resulting in the potential for serious negative physical and psychosocial outcomes for all 67 residents residing at the facility. Findings include: During an interview on 2/12/18 at 1:04 PM, Nursing Home Administrator (NHA) A reported that the Quality Assessment and Assurance (QAA) committee met monthly. She stated that herself, the Director of Nursing (DON), the Medical Director and Nurse managers were among those who attended the monthly meetings. Per her report, the Pharmacist attended quarterly. NHA A reported that the facility identified problems in the daily stand-up meetings (meetings attended daily by clinical care staff), through the abaqis program (resident rounding) where all data was put in the computer, resident council, monthly meetings, sub-committees, Ad-Hoq (meetings held when an issue arose that the facility wanted a response to) and quarterly meetings when the DON, NHA met with the regional team to identify things. NHA A also stated that problems could have been identified by something such as an incident that occurred or observations of things within the facility. When asked how the facility implemented changes, NHA reported that it depended on what it was. She stated that facility did staff education and got a committee together. Once the facility identified the problem, they educated, audited and made sure that it worked. If it didn't work, they would figure out what they did wrong and how they could improve on it. Depending on what it was, they tried to resolve it within a month. If it wasn't resolved, they went back to the issue. NHA A reported that staff was informed of implemented changes through education. She stated, We are probably not doing so good with telling staff how the concern was resolved. When asked if concerns related to call lights had come to the attention of the QAA/Quality Assurance Process Improvement (QAPI) committee, NHA A reported that call light times were talked about in the facility Quality Assurance (QA) meeting. She reported that the concern first came to the attention of the facility around the end of December 2017 or the beginning of January 2018. NHA A reported that there were complaints on the late evening shift, so she started going to the facility periodically during the night to see how it was going. NHA A reported, we got so busy with other things that we are nowhere near fixing the problem. NHA A further stated that the complaints she was hearing were from the residents, specifically about the midnight shift. When asked if there was a goal for call light response time, NHA A reported that she was unsure if the facility had a policy for call lights. She reported that any staff passing by should have been responding to the call light to see if they could meet the need. If they could not meet the need, they should have found someone who could. The initial person to respond to the call light should have followed up to make sure the need was addressed if they were unable to personally meet the need. NHA A was reluctant to discuss a recent QAA/QAPI project, stating that she really did not want to do so that until the survey team was exiting the facility. She then stated a recent project was hydration and water pass. The facility worked on what they could do that was fun for hydration. When managers did daily rounds they were looking at the date on beverage cups and if it was consumed. When asked if falls had been identified as a concern by the QAA/QAPI committee, NHA A stated that the facility trended falls and then that was taken to QA. She stated that the facility had a morning meeting that had flip charts just on falls, stating that it showed the systems that needed to be reviewed. When asked to clarify, she stated the systems included whether the physician and family had been notified, if the care plan had been updated and if pain was assessed or addressed. According to the facility policy titled, FALLS PRACTICE GUIDE, dated 12/2011, .Management of falls is routinely audited through the utilization of QAPI audit tools. Utilize the Falls Process Observation Tools, interview tools or center task tools to identify potential or actual system issues. The results of the audits are submitted to the Quality Assessment and Assurance (QAA) Committee for review and follow up as clinically indicated. Patient falls are tracked by time, location and causative factors. The data is reviewed to identify any trends. The results are submitted to the QAA Committee for review and recommendation as indicated . During the interview on 2/12/18, NHA A was unaware of any identified concerns related to Activities of Daily Living (ADL's) or oral care. During an interview on 2/13/18 at 8:56 AM, (NAME)tered Nurse (RN) QQ reported that CNA's were instructed that everyone needed oral care in the morning and at bedtime. She stated that the facility was doing education consistently with CNA's that oral care needs to be done .We have meetings every day and go over concerns. (NAME)l care is an overall deficient practice here. We know that it is an issue . During an interview on 2/13/18 at 10:16 AM, CNA K stated that any education was normally given facility-wide. She did not recall any recent education regarding oral care.
F 0880 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain infection control practices to prevent infection for 4 residents (Residents #11, 28, 44 and 71), out of 25 residents reviewed for infection control practices, out of a total sample of 28 residents, resulting in infection of a wound and surrounding boney structures and a urinary tract infection (Resident #44) resulting in the potential for infection during a clean dressing change (Resident #71) and the potential for cross contamination from contaminated items (Residents #11 and 28). Findings include: Resident #44 According to a facility face sheet dated 2/8/18 at 10:56 AM, Resident #44 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. During an observation of Resident #44's wound care on 02/07/18 01:34 PM it was observed that Certified Nurse's Aide (CNA) O donned gloves and emptied the Foley indwelling catheter bag (drains urine from the bladder) of a clear yellow urine into a graduated container. No cleansing with alcohol was noted of the Foley drainage spout. CNA O then with her dirty gloved hand, was observed to pull at the top of the dressing cart to move it to the side to be able to walk by it to the bathroom. Clean dressing supplies were observed on top of this cart, no barrier was observed under the clean dressings. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0880 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 21) preparation of the top of the cart such as disinfection was observed. Resident #44 was positioned lying in bed on her right side and 2 pressure wounds were observed, one under left buttock and one at the sacrum. Resident #44 stated she was admitted with the wounds. Resident had a bowel movement, and this was cleansed by the CNA's with adult disposable wipes and removed with the brief. No barrier observed placed under Resident #44 on bed after cleansing of the bowel movement by CNA O. LPN X donned gloves washed the wounds with a saline squirt (a single use small saline plastic container) and gauze. The buttock wound was observed to be washed from the outside skin into the base of the wound (dirty skin to clean base of the wound). Dirty dressing supplies were discarded open trash bag on the bed. LPN X was observed to prop up the saline squirt on an item in the dirty garbage bag so that the spout wouldn't leak saline. LPN X removed her gloves and was observed to cut the calcium alginate dressing needed. This cut piece was placed on top of the open dressing sleeve. LPN X was not observed to perform hand hygiene after removing her gloves. Alcohol hand gel was observed on top of the dressing cart. LPN X applied clean gloves. No hand hygiene was observed before donning new gloves. LPN X pulled out packing gauze from a container, applied saline to the gauze and placed in the lower left buttock wound. LPN X was then observed to cut the packing gauze with her scissors near the residents body after it had been packed in the resident's wound and then pulled more packing gauze from a new vial and cut this with her used scissors. LPN X was not observed to have cleaned her scissors before cutting a clean piece of packing gauze. LPN X was observed to have applied dermaskin (a skin protectant) spray to peri (around) wound AND wound packing areas then applied an occlusive foam dressing to the buttock wound. LPN X then discarded her used gloves into the garbage bag and was observed to use alcohol hand gel and applied clean gloves. The sacral wound was then observed cleansed by LPN X with the use of the propped up saline squirt applied to gauze (with clean gloves on). Again LPN X cleansed from the outside skin to the inner wound, from outside of wound in. LPN X took off her dirty gloves and applied new gloves, no hand hygiene observed. LPN X cut a calcium alginate piece with the uncleansed scissors and applied it to the wound bed. This sacral wound was observed sprayed with dermaskin around the wound AND over the wounds calcium alginate. LPN X then took off gloves and no hand hygiene observed, applied new gloves and applied foam dressing over the sacral wound. No dates were observed to be placed on either ischial or sacral wound dressings. CNA O was then observed to remove the garbage bag with gloved hands from the bed. No hand hygiene was observed after removal of CNA O's gloves. CNA O asked LPN X if the calcium alginate needed to be saved. LPN X replied, Yes, it's expensive and CNA O was observed to place the dressing with her ungloved and un cleansed hands into the original open package and placed the dressing in the dressing cart. CNA O was observed to have pulled the dressing cart out of the room and into the hall. The majority of articles emphasize the need for handwashing before and after contact with catheters and drainage bags, and the use of clean non-sterile gloves ((NAME) et al, 2007; CPHVA, 2005; Pellowe and(NAME) 2004;(NAME) 1997) . Both(NAME)(1997) and NICE (2003) specify the use of disposable plastic aprons to protect clothing from exposure to body fluids, secretions or excretions.(NAME)(1997), Penfold (1999) and(NAME)and Lister (2004) recommend that the outlet tap should be cleaned with a 70% [MEDICATION NAME] alcohol swab before opening and after closing. (https://www.nursingtimes.net/evidence-care-of-urinary-catheters-and-drainage-systems/ 5.article) Review of a document for Resident #44, Urine Culture dated 10/18/17 at 3:45 AM reflected, Resulting lab: > (greater than) 100,000 CFU/ml (colony forming units per milliliter) Proteus (P.) mirabilis Strain 1 and > 100,000 CFU/ml Proteus (P.) mirabilis Strain 2. P. mirabilis is not a common cause of UTI in the normal host. Surveys of uncomplicated [MEDICATION NAME] or acute [MEDICAL CONDITION] show that P. mirabilis comprises only a few percent of cases. Even in patients with recurrent UTI, the incidence of infections by this organism is only a few percentage points higher. Why have we conducted and now are proposing to continue intensive studies of the pathogenesis of P. mirabilis? The answer lies in the fact that this organism infects much higher proportions (up to 44%) of patients with complicated urinary tracts; that is, those with functional or anatomic abnormalities or with chronic instrumentation such as long-term catheterization, making it the most common nosocomial (medical facility acquired) infection. While infecting the urinary tract, P. mirabilis has a predilection for the kidney (involving the kidney). Finally and importantly, not only does this bacterium cause [MEDICATION NAME] (bladder inflammation) and acute [MEDICAL CONDITION] (inflammation of the kidney), but the production of urinary stones, a hallmark of infection with this organism, adds another dimension to these already complicated urinary tracts. (http://www.umich.edu/~hltmlab/research/mirabillis/infection.htm) Proteus mirabilis is a common facility acquired infection. Review of a facility policy titled, Skin Practice Guide dated issued 1/2013 reflected, Wound Management: .Dressing changes are performed using a non-sterile, clean technique unless otherwise ordered by the attending physician. In general, the following guidelines are considered when performing treatments: adhere to principles of infection control - separate clean and dirty, provide a barrier filed for treatment supplies, appropriate use and changing of gloves, maintain appropriate precautions, appropriate cleaning of the wound bed (center of wound to outside perimeter), cleansing of scissors, hand washing, disposal of soiled dressings .Dressings are dated and initialed. Review of a facility policy titled, Dressing (NAME)e: Non sterile (Clean) dated revised 4/2016 reflected, .Perform hand hygiene (each time you are entering or leaving a room and when you are going form dirty to clean) .Set up area: disinfect over bed table using an EPA approved disinfectant. While over bed table (surface) is drying, gather supplies and bring them to the patients room .perform hand hygiene upon entering. Place a clean barrier on the over bed table (surface) then place hand sanitizer, equipment and supplies on top of barrier. Do no open supplies at this point. Place waste receptacle, with leak proof bag under the over bed table .Perform hand hygiene Place procedure towel (wound drape) or clean towel under the area for treatment. Perform hand hygiene and apply latex free non-sterile drugs. Remove soiled dressing and discard in trash bag .Remove soiled gloves, discard and perform hand hygiene. Prepare a clean filed: arrange supplies on table, open packages to reveal supplies, if dressing need to be cut to size, use cleans scissors (disinfect the scissors with an EPA approved disinfectant before and after using), label tape used to secure dressing with caregiver initials and date. Perform hand hygiene and apply latex free non sterile gloves. Cleanse wound per physician's orders [REDACTED]. Clean wound then peri wound. Removed soiled gloves, discard. Perform hand hygiene and apply latex free non sterile gloves. Apply dressing per physician's orders [REDACTED]. Remove procedure towel from under patient and discard. Dispose of soiled and used disposable equipment and supplies in waste bag. Remove soiled gloves and discard. Perform hand hygiene .Return equipment and used supplies to designated area. Clean, sanitize, disinfect or dispose as indicated. Perform hand hygiene after disposing waste and or cleaning equipment. Review of a facility policy titled, Hand Hygiene dated 12/2009 reflected, Purpose: To decrease spread of infection .When to wash hands or use hand rub: before applying and after removing gloves .after contact with body fluids or excretions. Mucous membranes, non-intact skin and wound dressings if hands are not visibly soiled .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient . During an Infection Control interview on 02/07/18 at 02:10 PM with DON B, Corporate Quality Assurance (CQA) Y and Unit Manager (UM) CC, DON B stated she has been DON at the facility for a little over a week. DON B has had formal training on Infection Control facility surveillance. It was asked if hand hygiene audits have been done. UM CC confirmed she has watched handwashing but does not have documentation of who she watched, when or if any follow up training was required. UM CC and DON BB was asked about dressing change procedure and hand hygiene. DON B stated hand hygiene needs to be done before and after donning your gloves, remove dressing you wash your hands. Scissors are to be cleansed before and after each use. Dressings that are open and cut are considered used and need to be thrown away. A barrier needed to be on top of cart, under the dressing supplies. All three confirmed that propping saline squirts inside dirty garbage bag on bed was not a good infection control practice. UM CC stated that the Foley spout needed to be cleansed with alcohol before emptying, and touching the clean dressing cart touch with dirty gloves should not have occurred. On 02/07/18 at 03:49 PM during a review of medical records the records reflected, OSTEO[DIAGNOSES REDACTED] OF VERTEBRA (back bones), SACRAL AND SACR[NAME][NAME]CYGEAL REGION (lower back and tail bone area, where Resident #44 pressure ulcer is located) 12/8/2017. [DIAGNOSES REDACTED] (is): Inflammation of the bone due to infection . Both the bone and the bone marrow may be infected. Symptoms include deep pain and muscle spasms in the area of inflammation, as well as fever. Treatment includes bed rest, use of antibiotics, and sometimes surgery to remove dead bone tissue. (https://www.medicinenet.com/script/main/art.asp?articlekey=4681) Review of a document for Resident 344 titled, EMAR (electronic medication administration record) dated 10/1 to 10/31/17 reflected, [MEDICATION NAME] Capsule (an antibiotic) Give 100 mg (milligrams) via G (gastric) tube every 12 hours for [MEDICAL CONDITION] (wound) for 20 administrations) on 10/18/17 and changed on 10/19/17 to [MEDICATION NAME] Mono (an antibiotic) 100 mg cap Give 100 mg via G tube every 12 hours for [MEDICAL CONDITION] for 20 administrations. Resident #44

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	625 36TH ST SW WYOMING, MI 49509

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 0880 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 22) required treatment of [REDACTED]. Resident #28 According to a facility face sheet dated 2/12/18 at 2:46 PM, Resident #28 was a [AGE] year old male admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. On 02/05/18 at 01:48 PM an observation was made of Resident #28's urinal. Resident #28 was not present. An empty hand held urinal was observed on over bed table. No barrier was observed under this urinal. On 02/07/18 at12:59 PM, an observation of the Resident #28's room, Resident #28 was not present. An empty hand held urinal was observed on the bedside dresser. During an observation on 02/08/18 at 08:46 AM Resident #28 was observed in bed. Over bed table was over his lap. An empty tray of food was in front of him. Resident #28 stated he is still hungry. Resident #28's empty hand held urinal was observed on the over bed table next to his food tray, again no barrier under the urinal was observed. During an interview on 02/08/18 at 01:22 PM with UM CC, she stated a urinal should be on a barrier on the table and care planned as such. UM CC stated the facility tries to teach residents about urinal placement after use. UM CC confirmed that there is no care planning regarding urinal placement for Resident #28. According to Mosby's Textbook for Nursing Assistants (5th ed., 2000), Remind men to not place urinals on over bed table and bedside stands. The over bed table is used for eating and as a work surface. Bedside stands are used for supplies. For these reasons, table surfaces must not be contaminated with urine. Resident #71 A review of Resident #71's admission record, dated 2/7/18, revealed Resident #71 was a [AGE] year old resident admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. During an interview on 02/05/18 at 12:13 PM, Resident#71 stated her foot was infected and stinking, but it wasn't doing that any more. A white dressing was observed around the resident's lower right leg and foot. Resident #71 stated that it was caused because of some medication she was given and that it was painful. A Review of Resident #71's Medical Practitioner Note from Physician Assistant (PA) Z revealed that on 01/18/2018 the reason for the appointment was; 1. Wounds to right lower leg and foot PA Z documented that I have been consulted by Doctor V to evaluate (Resident #71) for multiple wounds to her right lower leg and foot. She was hospitalized from 12/27-1/4 at (name of hospital) for a [MEDICAL CONDITION] ([MEDICAL CONDITION] of the right lower extremity. In the hospital she was placed on Argatroban. She then developed bullous [MEDICAL CONDITION], so the medication was stopped and she was placed on [MEDICATION NAME]. Staff have been applying calcium alginate AG to the wounds daily. (Resident #71) has a history of [MEDICAL CONDITION] (end stage [MEDICAL CONDITION]) on HD ([MEDICAL TREATMENT]), type 2 diabetes and hypertension. Staff state her appetite has been good. At this time resident is lying in her bed. She states she has a lot of pain related to the wounds. Examination of Resident #71's skin revealed, Ulcer to the right lateral foot and ankle measures 13.0 x 7.0 cm, wound base is 40% necrotic eschar, 40% slough and 20% granulation tissue, there is moderate serous drainage with an odor, ulcer to the dorsom of the right foot measures 5.0 x 2.9 cm, the wound base is 80% eschar, 10% slough and 10% granulation tissue, there is scant serous drainage with an odor, ulcer to the right anterior lower leg measures 4.7 x 3.2 cm, the wound base is 85% eschar, 10% slough, and 5% granulation tissue, there is scant serousanguineous drainage with an odor, the ulcer to the right medial lower leg measures 8.5 x 2.8 cm, the wound base is 95% eschar and 5% granulation tissue, there is scant serous drainage with an odor, I note the skin to the distal right foot is thin and shiny with little subcutaneous fat as often seen in PAD Assessments 1. (NAME)ralized skin eruption due to drugs and medicaments Resident #71 treatment for [REDACTED]., she is currently on aspirin 81 mg daily, if her wounds are not improving we may need to consider increasing this to 325 mg. During a dressing change on 02/07/18 at 02:30 PM, for Resident #71, the following observations were made on (NAME)tered Nurse Supervisor (RNS) BB. During the removal of the residents old ABD pads dated 2/6/17 RNS BB stated he needed some saline from the his cart in the hallway. RNS BB removed gloves to exit room and get packages of saline. Did not perform hand hygiene after removing gloves. Opened room door and treatment cart. Returned to room, used hand sanitizer and applied new gloves. RNS BB continued to cleanse wound with gauze and soap and water. The nurse reached into an open package of gauze pads several times with gloved hands while cleansing the wound. Resident #71 wound covers top of right foot and lateral malleolus, a yellow wound bed to top of foot and the wounds extended up anterior and bilateral aspects of right shin and towards posterior aspect of extremity. RNS BB removed old barrier towels from beneath RLE and replaced, the replacement towel had sanguinous drainage. RNS BB removed his gloves and used hand sanitizer. RNS BB then dried the residents wounds with gauze. RNS BB removed gloves, applied hand sanitizer then new gloves. RNS BB used multiple cotton tipped applicators to apply the (NAME)dine cream, however the same cotton tipped applicator was used to apply (NAME)dene cream to multiple wound beds. RNS BB applied ABD pads over the residents wounds. RNS BB secured the ABD pads with a stretch gauze. The saturated dressing supplies thrown in the trash. RNS BB placed the saturated towels on floor at bedside. RNS BB used the same scissors that removed the old bandage to cut excess stretch gauze at the end of the dressing change. RNS BB dated and initialed the new dressing. Serosanguinous drainage noted to pillow case after RNS BB removed towels, Resident #71 placed her left foot and leg over the area of drainage on the pillow case along with her freshly bandaged right foot. Soiled barrier towels from floor were placed in a trash bag. Gloves removed, hand sanitizer used. RNS BB stated to Resident #71 that he would have a CNA come in and change her bedding and clothing. 2/12/18 02:20 PM During an Interview with (NAME)tered Nurse BB stated that he discarded all of the rest of the package of gauze that was left from the dressing change on 2/7/18. On 02/12/18 at 12:49 PM Certified Nurses Aide (CNA) O was observed providing hygiene care for Resident #11 in his bathroom. CNA O placed a wash cloth soiled with fecal matter in sink and preceded to take another wash cloth out of the sink to continue with hygiene care. CNA O washed Resident #11 face with a cloth that came out of the sink that had the cloth with fecal matter on it. CNA O did not disinfect Resident #11 sink when she was done providing hygiene.
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immunize one resident (Resident #44) out of 5 residents reviewed for immunizations, from a total sample of 28 residents, resulting in the potential to have pneumococcal pneumonia (infection within the lungs), bacteremia (blood infection), meningitis (infection around the brain and spine), complications from pneumococcal disease and possible death. Findings include: According to a facility face sheet dated 2/8/18 at 10:56 AM, Resident #44 was a [AGE] year old female admitted into the facility on [DATE] with the Diagnoses: [REDACTED]. During a review of Resident #44's medical record on 02/07/18 at 03:44 PM the medical record reflected, Influenza 10/22/17, Pneumococcal 9/12/12, TB 6/23/17. There was no documentation regarding the Prevnar 13 (PCV13) vaccine. On 02/08/18 11:40 AM during an interview with Director of Nursing (DON) B, she confirmed the date the Prevnar 13 vaccine was given to Resident #44 cannot be found. DON B stated if a Pneumococcal ([MEDICATION NAME] 23 or PPSV23) vaccine was given in 2012 a Prevnar 13 vaccine can be given now. During an interview on 02/08/18 at 01:09 PM with Unit Manager (UM) CC confirmed she is responsible for chart reviews for immunizations (and infection control). UM CC was asked resident has Pneumococcal or [MEDICATION NAME] 23 vaccine in 2012 can she have the Prevnar 13 vaccine. UM CC Confirmed Resident #44 should be eligible for the Prevnar 13 vaccine. UM CC stated upon admission she looks for the vaccines a resident has had. UM CC state if a resident has had the first (Pneumococcal vaccine or [MEDICATION NAME] 23) and it's been 5 years, the facility can offer the second pneumonia vaccine known as Prevnar 13. Review of a facility policy titled, Immunizations issued 6/2016 reflected, Immunize persons with PPSV 23 with the following indications: Adults [AGE] years with the following: Chronic medical problems .residents of nursing homes or long term care facilities. This policy continues with, Recommendations for 13 Pneumococcal Conjugate Vaccine (PCV 13). If ordered by attending physician or medical director, immunized persons with PCV 13 with the following indications: Adults aged 65 or older with certain medical conditions who have not previously received PCV 13. Adults and older with certain medical conditions who have not previously received PCV 13. Medical conditions include: .[MEDICAL CONDITION]. This policy also reflected the recommendations from the CDC guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. BUILDING _____ B. WING _____	**02/14/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-CRESTVIEW	**625 36TH ST SW WYOMING, MI 49509**

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 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 23) Many adults are at risk for pneumococcal disease. Two vaccines provide protection against this serious and sometimes deadly disease . Each year in the United States, pneumococcal disease kills thousands of adults, including 16,000 adults [AGE] years or older. Thousands more end up in the hospital because of pneumococcal disease with severe infections of the lungs (pneumonia), bloodstream (bacteremia), and lining of the brain and spinal cord (meningitis). Vaccines are the best way to prevent pneumococcal disease. Two vaccines help prevent pneumococcal disease: PCV13 (pneumococcal conjugate vaccine), PPSV23 (pneumococcal [MEDICATION NAME] vaccine). PCV13 protects against 13 strains of pneumococcal bacteria and PPSV23 protects against 23 strains of pneumococcal bacteria. Both vaccines provide protection against illnesses like meningitis and bacteremia. PCV13 also provides protection against pneumonia. (https://www.cdc.gov/features/adult-pneumococcal/index.html) CDC (Center for Disease Control) recommends vaccination with the pneumococcal conjugate vaccine (PCV13 or Prevnar 13®) for All adults [AGE] years or older. CDC recommends vaccination with the pneumococcal [MEDICATION NAME] vaccine (PPSV23 or [MEDICATION NAME]®) for All adults [AGE] years or older .CDC recommends pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or [MEDICATION NAME]®) for all adults [AGE] years or older: . Give 1 dose of PCV13 to all adults [AGE] years or older who have not previously received a dose. Give 1 dose of PPSV23 to all adults [AGE] years or older at least 1 year after any prior PCV13 dose and at least 5 years after any prior PPSV23 dose. Adults who received one or two doses of PPSV23 before age 65 should receive one final dose of the vaccine at age 65 or older. (https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html) During an interview on 02/08/18 at 01:09 PM with Unit Manager (UM) CC confirmed that Resident #44 had a [DIAGNOSES REDACTED].