STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235444	A. Building B. Wing	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Nursing Center	16588 Schaefer Detroit, MI 48235

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 - Minimal harm or potential for 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** 39465 This citation pertains to intakes#: MI00121866, MI00121747, and MI00122147. Based on interview, and record review, the facility failed to notify the physician of missed pain medications for two Residents (R#6, and R#8) of four residents reviewed for medication administration, resulting in prolonged uncontrollable pain, delay in treatment and frustration. Findings include: R#6 Resident #6 was observed on 8/24/21 at 2:00 p.m. in bed, alert and able to be interviewed. R#6 stated, I believe it was August 1st on the midnight shift, I didn't get my 8:00 p.m. and 3:00 in the morning medication. I know my scheduled times for my pain medications, and I didn't get them. The one scheduled at 4:00 in the morning they usually give it to me an hour early at 3:00 a.m. I called 911 because I didn't get my pain medications, I heard it was only one nurse, and I was scared something might happen to me. Review of the physician's orders revealed, Resident #6 scheduled pain medications times and as needed (PRN) pain medications frequency were as following: Morphine sulfate ER (Extended Release) tablet 60 mg (Milligrams) give one tablet by mouth three times a day related to other chronic pain ordered date 1/31/2021, Ibuprofen tab 600 mg give one tablet by mouth every six hours as needed for pain order date 5/30/2019, Morphine Sulfate (Concentrate) Solution 100 mg/5ml give 0.25 ml by mouth every three hours as needed for pain break through order date 1/25/2021. Review of the Medication Administration Record (MAR) revealed, R#6 scheduled Pain Medication times for Morphine Sulfate ER tablet 60 mg were scheduled for 0400 (4:00 a.m.), 1200 (12:00 p.m.), and 2000 (8:00 p.m.). R#6's Medication Administration Record (MAR) for the date of 8/1/2021and 8/2/2021 revealed, the scheduled Morphine Sulfate ER tablet 60 mg at 0400 (4:00 a.m.) and 2000 (8:00 p.m.) doses had no nurse's signature indicating the medication was given. Review of the Nurses Progress notes revealed no documentation of the physician notified of missed medication, no documentation of PRN pain medication given for pain. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pharmacy Controlled Substance Proof-Of-Use Record revealed no documented nurses' signatures of R#6 scheduled pain medication (Morphine sulfate 60 mg) doses given on 8/1/2021at 8:00 p.m. and on 8/2/2021 at 4:00 a.m. No documented nurse's signatures of R#6 PRN Ibuprofen tab 600 mg give one tablet by mouth every six hours for pain, and Morphine Sulfate (Concentrate) Solution 100 mg/5ml give 0.25 ml by mouth every three hours for pain break through given. Interviewed the facility's Director of Nursing (DON) B regarding R#6 missed doses of scheduled pain medications and PRN pain medications administration. DON B confirmed she was aware of R#6's scheduled pain medications was not given on 8/1/2021 at 8:00 p.m. and 8/2/21 at 4:00 a.m., and aware of R#6 calling the police because of the missed medications. DON B verified the police officer came into the facility around 6:00 a.m. that morning and talked to her regarding some residents did not get their medications. DON B stated,I followed up on the alleged missed medications. R#6 did not get his medications, they were late. DON B verified the physician was not called regarding the missed medications and to administer PRN pain medications. DON B verified after talking to the resident taking his complaints at 6:00 a.m., there was no follow up to ensure the resident receive all his medications. DON B also confirmed no PRN pain medication were administered. R#8 Review of the face sheet on 8/25/2021 at 4:35 p.m. R#8 was initially admitted into the facility on [DATE] with diagnoses that included, anxiety, schizophrenia, present of ca diabetes mellitus type two, fracture of lumbar vertebra, history of pain, heart failure, chronic kidney disease, and anxiety disorder. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#8 was cognitively intact with a BIMS score of (15). Review of the physician's orders revealed R#8 scheduled pain medications are as following: Norco Tablet 5-325 mg (Hydrocodone Acetaminophen) give one tablet by mouth every 12 hours for pain. Review of the Medication Administration Record (MARs) for the date of 8/1/2021 revealed no nurses signature indicating the pain medication was administered. Review of R#8 Pain level value dated 8/26/2021 documented, Pain level of (9). Review of the Nurse's Progress notes with no documentation of the physician notified of R#8 missed medications for the date of 8/1/2021. Review of the facility's Medication Pass Guidelines dated 8/2021 revealed no documentation regarding missed medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 This citation pertains to Intakes#: MI00121747, MI00121866, MI00122147. Based on interview, and record review the facility failed to administer scheduled and as needed (PRN) pain medications per physician order for two Residents (R#6, and #8) of four residents reviewed for pain management, resulting in anger, frustration, and increased uncontrolled pain. Findings include: R#6 Resident #6 was observed on 8/24/21 at 2:00 p.m. in bed, alert and able to be interviewed. R#6 stated, I believe it was August 1st on the midnight shift, I didn't get my 8:00 p.m. and 3:00 in the morning medications. I know my scheduled times for my pain medications, and I didn't get them. The one scheduled at 4:00 in the morning they usually give it to me an hour early at 3:00 a.m. I called 911 because I didn't get my pain medications, I heard it was only one nurse, and I was scared something might happen to me. Review of the face sheet on 8/24/21 at 2:45 p.m., revealed R#6 was admitted into the facility on [DATE] with diagnoses that included anxiety disorder, osteoarthritis, chronic pain, hemiplegia and hemiparesis, cerebral infarction, and palliative care (palliative care is an interdisciplinary medical caregiving approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex illness). R#6 is receiving Hospice care. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#6 was cognitively intact with a BIMS score of (15). Review of the physician's orders revealed, Resident #6 scheduled pain medications times and as needed (PRN) pain medications frequency were as following: Morphine sulfate ER (Extended Release) tablet 60 mg (Milligrams) give one tablet by mouth three times a day related to other chronic pain ordered date 1/31/2021, Ibuprofen tab 600 mg give one tablet by mouth every six hours as needed for pain order date 5/30/2019, Morphine Sulfate (Concentrate) Solution 100 mg/5ml give 0.25 ml by mouth every three hours as needed for pain break through order date 1/25/2021. Review of the Medication Administration Record (MAR) revealed, R#6 scheduled Pain Medication times for Morphine Sulfate ER tablet 60 mg were scheduled for 0400 (4:00 a.m.), 1200 (12:00 p.m.), and 2000 (8:00 p.m.). R#6's Medication Administration Record (MAR) for the date of 8/1/2021and 8/2/2021 revealed, the scheduled Morphine Sulfate ER tablet 60 mg at 0400 (4:00 a.m.) and 2000 (8:00 p.m.) doses had no nurse's signature indicating the medication was given. Review of the Nurses Progress notes revealed no documentation of R#6 getting pain medications, no pain assessment/evaluation documented. Review of R#6 Pain Level values dated 8/22/2021 documented, Pain level of (6). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Pharmacy Controlled Substance Proof-Of-Use Record revealed no documented nurses' signatures of R#6 scheduled pain medication (Morphine sulfate 60 mg) doses given on 8/1/2021 at 8:00 p.m. and on 8/2/2021 at 4:00 a.m. No documented nurse's signatures of R#6 PRN Ibuprofen tab 600 mg give one tablet by mouth every six hours for pain, and Morphine Sulfate (Concentrate) Solution 100 mg/5ml give 0.25 ml by mouth every three hours for pain break through given. Review of the Hospice care plan initial date of 1/27/2021 documented, I am currently under .Hospice care related to resident has terminal diagnoses of Chronic Obstruction Pulmonary Disease (COPD) .Comfort measures will be maintained, and episodes of pain/discomfort will be relieved within one hour of intervention . Interviewed the facility's Director of Nursing (DON) B regarding R#6 missed doses of scheduled pain medications and PRN pain medications administration. DON B confirmed she was aware of R#6's scheduled pain medications was not given on 8/1/2021 at 8:00 p.m. and 8/2/21 at 4:00 a.m., and aware of R#6 calling the police because of the missed medications. DON B verified the police officer came into the facility around 6:00 a.m. that morning and talked to her regarding some residents did not get their medications. DON B stated, The police wanted to see the residents' records for med. (Medication) Pass, and I decline because it was a HIPPA (Health Information Privacy Protection Act) violation. DON B statated,I followed up on the alleged missed medications. R#6 did not get his medications, they were late. DON B verified the physician was not called regarding the missed medications and to administer PRN pain medications. DON B verified R#6 was upset, and he did not get any medication after it was brought to her attention. DON B verified after talking to the resident taking his complaints at 6:00 a.m., there was no follow up to ensure the resident receive all his medication and pain level evaluation. DON B confirmed no PRN pain medication were administered. Reinterviewed R#6 on 8/25/21 at 4:20 p.m. regarding his missed doses of pain medications. R#6 stated, OH yes, I was in pain. My pain was about a (10) on a scale of (10). I didn't get any pain medications until about 10:00 that morning. She (DON) did come and talked to me about 6:00 a.m. that morning, but I didn't get pain meds until 10:00. R#8 Review of the face sheet on 8/25/2021 at 4:35 p.m. R#8 was initially admitted into the facility on [DATE] with diagnoses that included, anxiety, schizophrenia, present of ca diabetes mellitus type two, fracture of lumbar vertebra, history of pain, heart failure, chronic kidney disease, and anxiety disorder. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], R#8 was cognitively intact with a BIMS score of (15). Review of the physician's orders revealed R#8 scheduled pain medications are as following: Norco Tablet 5-325 mg (Hydrocodone Acetaminophen) give one tablet by mouth every 12 hours for pain. Review of the Medication Administration Record for the date of 8/1/2021 revealed no nurses signature indicating the pain medication was administered. Review of R#8 Pain level value dated 8/26/2021 documented, Pain level of (9). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of facility's Medication Pass Guidelines policy dated 8/2021 documented, Purpose: To assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing the administration of drugs in an accurate, accordance with State and Federal Guidelines .5. Administer medications within sixty minutes before or after the scheduled time. Unless otherwise specified by the physician .