STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235719	A. Building B. Wing	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to gain acknowledgement before entering Resident rooms for three (#'s 18, 37, and 94) of four Residents reviewed for dignity, resulting in lack of privacy and respect for Resident's personal space and Resident feelings of frustration. Findings include: Record review of Resident #18's medical record on 9/23/19 revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis, neuromuscular dysfunction of the bladder, Methicillin Resistant Staphylococcus Aureus (MRSA- drug resistant organism) infection, and pressure ulcers. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to perform Activities of Daily Living (ADLs). On 9/24/19 at 10:23 AM, an interview was conducted with Resident #18 in their room. When queried regarding dignity and respectful treatment by facility staff, Resident #18 replied, They (staff) do no knock before they come in. With further inquiry, Resident #18 stated, It bothers me. Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD- respiratory disease), Atrial Fibrillation (irregular heart rate), and kidney failure with dialysis dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired, was independent with eating, and required extensive to total assistance to perform all other Activities of Daily Living (ADLs). On 9/23/19 at 1:42 PM, an interview was conducted with Resident #37 and Confidential Witness S in their room. The room door was closed during completion of the interview. At 2:05 PM, during the interview, Nurse A opened the door and entered Resident #37's room without knocking. Upon request for privacy during the interview by the Resident, Nurse A was observed standing in the doorway for approximately one minute before exiting the room. When queried regarding staff entering their room without knocking, Resident #37 and Confidential Witness S revealed staff enter the room without knocking frequently. With further inquiry, Resident #37 revealed they did not like it when staff just walked in to their room especially after their phone went missing. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #94 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included heart failure, Chronic Obstructive Pulmonary Disease (COPD), and respiratory failure. On 9/23/19 at 10:11 AM, an interview was conducted with Resident #94. During the interview, an unknown staff member was observed entering the room without knocking. After the staff member exited the room, Resident #94 was asked if staff typically knock before entering their room. Resident #94 replied, No they don't, and I don't appreciate it. An interview was conducted with the Director of Nursing (DON) on 9/24/19 at 4:47 PM. When queried if staff should knock before entering Resident's room per facility policy/procedure, the DON replied, Yes. Review of facility provided Admission Packet revealed, A facility must treat each Resident with respect and dignity and care for each Resident in a manner and in an environment that promotes . quality of life, recognizing each Resident's individuality .

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37668 Based on interview and record review, the facility failed to accurately record code status (level of medical interventions an individual wishes to have enacted in a medical emergency situation) for four (#'s 7, 37, 93, and 94) of six Residents reviewed for Advance Directives (legal documentation enabling an individual to specify end-of-life care decisions), resulting in lack of assessment and documentation of code status and the potential for a Resident to receive life sustaining medical treatment against their wishes. Findings include: Resident #37 Record review revealed Resident #37 was admitted into the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation (irregular heart rate), and dialysis dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired. Record review on [DATE] revealed Resident #37 did not have a code status order listed in the Electronic Medical Record (EMR). On [DATE] at 9:15 AM, an interview was conducted with Resident #37. When queried regarding their wishes pertaining to care and end of life, Resident #37 stated, If it gets that bad, just let me go. When asked if they would want Cardio-Pulmonary Resuscitation (CPR), Resident #37 replied, No. When asked if staff at the facility had discussed their wishes with them, Resident #37 indicated they had discussed it at the hospital when they were there. An interview and record review of Resident #37's medical record was completed with the Director of Nursing (DON) on [DATE] at 9:40 AM. Review of scanned documentation in the medical record revealed signed documentation indicating the Resident wanted full code status (everything completed to sustain life). On [DATE] at 9:46 AM, an interview was conducted with Resident #37 and the DON. When queried regarding their Advance Directives and wishes pertaining to care and end of life, Resident #37 stated, No, I don't want anything done. The code status in their medical record indicating the Resident was a full code was reviewed with the Resident and the DON at this time. When queried regarding the form, Resident #37 stated, They just ask all those questions when you get here. It's just too much, you just sign. I don't want that (full code status). At this time the DON indicated they would have the facility Social Worker readdress the Resident's code status with them. Record review revealed Resident #93 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, intestinal obstruction with surgical repair, and Clostridium Difficile (C-Diff- Contagious bowel infection). Review of the Clinical Admission Evaluation dated [DATE], revealed the Resident was alert and orientated to person, place, and time, required assistance for bed mobility and utilized a wheelchair for ambulation. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #93's paper and electronic medical records on [DATE] revealed no documentation of code status and/or Advance Directives. Review of Resident #93's progress note documentation did not reveal code status having been addressed with the Resident. On [DATE] at 3:11 PM, an interview and record review was conducted with Nurse Q. When queried regarding documentation of Resident #93's code status, Nurse Q reviewed the medical record and stated, It's definitely not in there. With further inquiry regarding facility policy/procedures pertaining to code status and Advance Directives, Nurse Q stated, Well, I can tell you that everyone is a full code when they get here. When queried if nursing staff address code status with Residents and/or legal representatives upon admission, Nurse Q replied, No, honestly, I'm not sure. I think (Unit Manager E). I have seen them go into rooms with the paperwork. On [DATE] at 4:47 PM, an interview was conducted with the DON. When queried regarding Resident #93 not having a code status documented and/or Advance Directives within the medical record, the DON indicated they would review the Resident's chart. An interview was completed with the DON on [DATE] at 9:53 AM. The DON presented Advance Directive documentation for Resident #93 dated as completed on [DATE]. The documentation indicated the Resident was Do Not Resuscitate (DNR) Advance Directive status. When queried regarding the documentation, the DON revealed the Social Worker completed the documentation after the question was brought to them on [DATE]. No further explanation was provided. Record review revealed Resident #94 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included heart failure, Chronic Obstructive Pulmonary Disease (COPD) , and respiratory failure. Record review on [DATE] of Resident #94's electronic medical record revealed the Resident did not have a code status documented. Review of Resident #94's progress note documentation revealed a Social Services Note, dated [DATE], which revealed, SW met with resident at bedside. Resident stated son . is DPOA (durable power of attorney) and can bring in paperwork . On [DATE] at 4:47 PM, an interview was conducted with the DON. When queried regarding Resident #94 not having a code status documented within the medical record, the DON indicated they would review the Resident's chart. 40384 On [DATE], Resident #7's (R7) medical record was reviewed in the facility's new electronic medical record (EMR) database that began up and running on [DATE]. The medical record did not reveal an advance directive for R7. On [DATE], R7's medical record was reviewed in the electronic medical record that was previously used by the facility. The dashboard that reflects the resident's code status indicated Full Code, (interventions needed to restore breathing or heart functioning) however, upon review of the resident's uploaded advance directive, it revealed that the resident was a DNR (Do Not Resuscitate). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R7's medical record revealed that the resident was admitted into the facility on [DATE] with diagnoses that included: Cerebral Infarction, Anxiety Disorder and Pseudobulbar Affect (a nervous system disorder). R7's Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident was severely cognitively impaired and required total dependence for all Activities of Daily Living (ADLs). On [DATE] at 4:06 PM, Nurse A was asked where the code status of a resident is located. Nurse A stated, We look in [electronic medical record]. Nurse A was asked if they could locate it in the EMR where R7's code status was located. Upon looking, Nurse A could not locate the code status. Nurse A then stated, I can look in the other EMR (previous database used by the facility). Nurse A attempted several times to access the EMR with no sucess and then indicated, I'll be right back, as they left to head to a different unit. Five minutes later, Nurse A returned and stated, R7 is a full code. Nurse A was asked if there was another location where they could locate a code status of a resident, and they stated, No. On [DATE] at 8:19 AM, Nurse F and Nurse G were asked how they locate a resident's code status. They both stated in the EMR (the most current database), and if they needed additional information about a resident, they could locate it in the previous used EMR. On [DATE] at 2:50 PM, an interview was conducted with the Director of Nursing (DON) and was asked about the code status of R7 not being in the new EMR, in addition to the wrong code status being listed in the previous EMR. The DON offered no explaination. Record review of facility policy entitled, Advance Directive policy (Dated: [DATE] was completed on [DATE]. The policy revealed, The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care . The accuracy of Resident code statuses in the Electronic Medical Record (EMR) was not addressed in the policy.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to ensure timely submission of an Minimum Data Set (MDS) assessment for one (#1) of one Residents reviewed for completion and transmission of an MDS assessment, resulting in an MDS not being submitted in a timely manner (greater than 120 days) and inaccurate tracking of assessments. Findings include: Record review on 9/24/19 revealed Resident #1 was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident #1's MDS assessments revealed the following completed MDS assessments: -3/21/19: Entry -3/27/19: Admission- Scheduled 5-Day -4/3/19: Scheduled- 14 Day An In-Process Discharge- Return Not Anticipated MDS assessment dated [DATE] was also noted in Resident #1's medical record. An interview was conducted with Nurse R on 9/24/19 at 1:03 PM. When queried regarding Resident #1's discharge MDS indicating being in process, Nurse R stated, It may not be uploaded yet. When queried why an MDS from April would not have been uploaded yet, Nurse R replied, Oh no, it should have been loaded. With further inquiry, Nurse R stated, I don't know. I will have to research it and find out why it wasn't sent. An interview was conducted on 9/24/19 at 4:47 PM with the Director of Nursing (DON). When queried regarding the missing MDS assessment, the DON indicated there was a computer glitch in the system.

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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 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** 37668 Based on observation, interview and record review, the facility failed to ensure hygiene care was provided to one (#37) of four Residents reviewed, resulting in lack of assistance for care, lack of oral care, and unkept, visually dirty fingernails. Findings include: Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD- respiratory), Atrial Fibrillation (irregular heart rate), and kidney failure with dialysis dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and was independent to total assistance to perform Activities of Daily Living (ADLs). On 9/23/19 at 1:42 PM, an interview was conducted with Resident #37 and Confidential Witness S. The Resident was sitting in a chair in their room. The Resident's shirt was visually soiled with an unknown substance. The Resident's teeth were visually dirty with large amounts of plaque observed. Resident #37's fingernails were long and jagged with an unknown black substance observed under the end of their nails. When queried regarding level of assistance needed from staff to complete ADLs, Resident #37 revealed they were unable to ambulate independently. When asked how often they are assisted to brush their teeth, Resident #37 replied, Every other day. With further inquiry, Resident #37 revealed they would like to brush their teeth twice a day but are not able to go the bathroom without assistance and the staff do not offer to help. When queried how often they receive a shower, Resident #37 replied, Once a week. When asked if they were satisfied with showering once a week, Resident #37 indicated they were not and stated, That's all the time they (staff) have to help you. When queried if they had told staff they would like more than one shower a week, Resident #37 replied, They don't listen. Resident #37 then stated, They have a real, real, real shortage of people here. An interview was completed with Nursing Assistant T on 9/23/19 at 2:36 PM. When queried regarding how often Resident fingernails are cut and cleaned, Nursing Assistant T indicated nail care is provided when Residents receive showers. An observation of Resident #37's fingernails was completed with Nursing Assistant T at this time. When queried regarding Resident #37's fingernails being long, jagged, and having visible black colored substance under the nails, Nursing Assistant T stated, Oh no. Those need to be cut. They shouldn't be like that. No further explanation was provided. Review of Resident #37's care plans revealed a care plan entitled, I have an ADL self-care performance deficit r/t (related to) impaired balance (Initiated: 9/15/19). Care plan interventions included: -Bathing/Showering: I require extensive assistance by 1 staff with showers on Monday, Thursdays and as necessary (Initiated: 9/15/19) -Personal Hygiene: I require extensive assistance by 1 staff with personal hygiene and oral care (Initiated: 9/15/19) -Toilet Use: I require extensive assistance by 1 staff for toileting (Initiated: 9/15/19) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transfer: I require extensive assistance by 1 staff to move between surfaces as necessary (Initiated: 9/15/19) An interview was conducted with the Director of Nursing (DON) on 9/24/19 at 8:51 AM. When queried observation of regarding Resident #37's fingernails and teeth, the DON indicated ADL should be completed. No further explanation was provided. On 9/25/19 at 12:35 PM, Resident #37 was observed in their room, sitting in a chair. The Resident's teeth were visually soiled with large amounts of plaque noted. An interview was completed with the Resident at time. When queried regarding their teeth, Resident #37 revealed they had not brushed their teeth because no one had assisted them. Review of facility policy entitled, ADL (Activities of Daily Living), Functional Mobility, & Resident Care (Issued/Revised: February 2019) revealed, Nurses, nursing assistants, and therapy staff assist residents in their activities of daily living . Description of ADL services provided: Showers/Bed Baths . regular showering at least 2x weekly. Should showering be contraindicated, complete bed bath and provide shower on Resident's next scheduled shower day . Oral Care . Nail Care . Dressing .

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F 0684 Level of Harm - Minimal harm or potential for 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** 37668 Based on observation, interview and record review, the facility failed to promptly assess and treat an optic (eye) infection for one (Resident #93) of one Residents reviewed for assessment of optic infection, resulting in delay of treatment and Resident verbalization of pain and discomfort. Findings include: Record review revealed Resident #93 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, intestinal obstruction with surgical repair, and Clostridium Difficile (C-Diff- Contagious bowel infection). Review of the Clinical Admission Evaluation dated 9/9/19, revealed the Resident was alert and orientated to person, place, and time, required assistance for bed mobility, and utilized a wheelchair for ambulation. On 9/24/19 at 2:02 PM, Resident #93 was observed in their room in bed, positioned on their back. The sclera (white part of eye) of both Resident #93's eyes were red. A crusted, yellow colored material was noted around both of the Resident's eyes and on their eyelashes. An interview was completed with Resident #93 at this time. When asked about their eyes being red, Resident #93 stated, Yeah they hurt. They are crusting. I was getting eye drops before but then they quit. I don't know why. With further inquiry regarding when they had last received eye drops and what the eye drops were for, Resident #93 revealed they had not received any drops for their eyes since being admitted to the facility. When asked how long their eyes had been hurting, Resident #93 indicated it had been quite a while. Record review on 9/24/19 revealed no documentation pertaining to Resident #93's eyes being red with a crusted material. Review of Resident #93's Medication Administration Record (MAR) at this time revealed the Resident had not received any optic medications while a Resident at the facility. An interview was conducted with Nurse Q on 9/24/19 at 4:05 PM. When queried regarding observation of Resident #93's eyes being red, Resident statements, and lack of documentation pertaining to their eyes, Nurse Q indicated they were not aware of the Resident experiencing discomfort. When asked if they had observed the Resident's eyes being red, Nurse Q revealed they had. When asked if they had asked the Resident about their eyes, Nurse Q replied, No, some people just have dry eyes. When queried if dry eyes to the point of being red are addressed when observed by nursing staff per facility policy/procedure, Nurse Q stated, We do not always address if the Resident doesn't complain about it. An interview was conducted with the Director of Nursing (DON) on 9/24/19 at 4:47 PM. When queried regarding observation of Resident #93's eyes and Resident and staff statements, the DON indicated they were unaware and would have the Resident's physician see the Resident. When queried why the Resident's eyes had not been addressed prior to this time, the DON was unable to provide an explanation. Review of Resident #93's medical record on 9/25/19 revealed a new order to start Offloxacin 0.3% (antibiotic medication) two drops in both eyes on 9/25/19. A facility policy/procedure pertaining to assessment and/or change in condition was requested from the DON on 9/14/19 at 5:00 PM but not recieved by the conclusion of the survey. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided policy entitled, Documentation of Medication Administration (Dated 6/1/16) did not provide information pertaining to assessment.

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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 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** 37668 Based on observation, interview and record review, the facility failed to institute and operationalize policies and procedures to ensure care of pressure ulcers (wounds caused by pressure) per professional standards of practice, for two (#'s 14 and 18) of four Residents reviewed for pressure ulcers resulting in lack of implementation of interventions for a Resident with multiple stage three pressure ulcers, pressure ulcer worsening, unnecessary pain, and the likelihood for infection and decline in overall health status. Findings include: On 9/23/19 at 10:09 AM, an observation occurred of Resident #18 in their room. The Resident was laying in bed positioned on their back. The Resident's heels were positioned directly on the mattress. Heel boots (padded boots to protect/reduce pressure on heels) were observed sitting in a wheelchair in the room. An interview was conducted with the Resident at this time. When asked if they had a pressure ulcer, Resident #18 replied, Yes. With further inquiry, Resident #18 stated, They usually patch it (pressure ulcer) in the morning. When asked where the pressure ulcer was located, Resident #18 indicated they had sores on their buttocks and heels. When asked if the pressure ulcers were painful, Resident #18 replied, Yes. Record review of Resident #18's medical record on 9/23/19 revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis, neuromuscular dysfunction of the bladder, Methicillin Resistant Staphylococcus Aureus (MRSA- drug resistant organism) infection and pressure ulcers. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further indicated the Resident had four stage three (full thickness tissue loss) pressure ulcers and one unstageable pressure ulcer (wound bed covered by slough, white, stringy tissue, and/or eschar, black colored, necrotic tissue). Review of Resident #18's Resident Care Guide revealed the Resident was non weight bearing, utilized a mechanical lift for transfers, had pressure reduction devices in their chair and bed, and needed to be repositioned every 2 hours. The Resident Care Guide further revealed, Areas to Avoid . Coccyx/Buttocks . Heels . An interview was conducted with Resident #18 on 9/24/19 at 9:53 AM in their room. The Resident was observed in bed, positioned on their back with their heels positioned directly on the mattress. While laying in bed, the Resident was observed displaying facial grimacing while attempting to move their legs in bed. When asked if they were in pain, Resident #18 revealed they were. With further inquiry, Resident #18 indicated they were experiencing pain in their feet, heels, and buttocks. When queried regarding getting out of bed and repositioning, Resident #18 revealed they require assistance for turning and to get out of bed. When queried regarding the frequency staff reposition them in bed, Resident #18 laughed and indicated facility staff had still not fixed the broken drawer in their dresser. Upon request, Resident #18's dresser drawers and closet door were opened. Inside the closet door, a form entitled, Turn/Reposition Record was observed. The form contained one entry which revealed, Date/Time: 9/18, 10:30 AM; Position: B (Back) .(Facility Staff Initials) . When asked how often staff assist them to reposition in bed and in their wheelchair, Resident #18 indicated staff do not regularly reposition them in bed and not at all when they are in their wheelchair. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/25/19 at 8:30 AM, Resident #18 was observed laying in their bed positioned on their back. Wound care observation for Resident #18 was completed on 9/25/19 at 10:03 AM with Wound Care Nurse B, Nurse D and Nursing Assistant C. Upon entering the Resident's room, Resident #18 was observed positioned on their back in bed. Nurse D began by removing the dressing from the Resident's right heel by saturating the dressing with spray wound cleaner. The prior dressing was noted to have a moderate amount of dark colored drainage. The wound was irregularly shaped and larger than a baseball in diameter. The wound encompassed all of the Resident's heel and the medial aspect of the heel. The wound bed was black in color with necrotic tissue. The wound borders were white and beefy red colored tissue. Wound measurements were requested but not obtained. Nurse B was observed cleansing the wound bed and then applied a dressing with a dark colored ointment already in place on the dressing. When queried what the ointment was, Nurse B indicated they had pre-prepared for the wound care treatment and stated, It's hydrogel (wound ointment) and santyl (wound debriding ointment). The santyl is first (closest to the wound bed). The dressing on Resident #18's left heel was then removed in the same manner using wound cleaner. The prior dressing was noted to have a small amount of dark yellow and brown colored drainage. The wound was irregularly shaped and located directly over the Resident's heel. The wound bed was observed to have an oblong shaped black colored center surrounded by white and yellow tissue. The open wound bed was surrounded by reddened tissue and with a dark purple area observed on the distal side of the wound. When queried regarding wound measurements, Wound Nurse B stated, I only measure the open part. When asked about the observed dark purple area, Nurse B stated, I didn't see that. With further inquiry Nurse B revealed the dark purple area was non-blanchable and would need to be included in the wound measurements. Nurse B obtained measurements of the wound at this time and stated, It's 3.5 cm (long) by 1.5 cm (wide). After application of a dressing, Resident #18 was repositioned on their right by Nursing Assistant C, Nurse B and Nurse D. A dark colored substance was observed on the outside of the Resident's brief. Upon removal of the brief to complete the dressing change, the current dressing in place over the Residents sacral pressure ulcer was observed to be completely saturated with dark colored drainage which was noted on the Resident's brief. After the dressing was removed by staff, the Resident's coccyx and sacrum were observed to have a large, irregular shaped ruddy red colored area which encompassed two visible open wounds. The area was larger in length and width than a dollar bill. The open wound on the Resident's left parasacral area, contained within the ruddy red area, was egg shaped with unattached edges and visible tunneling and undermining. The wound bed had white, yellow and red colored tissue. When queried regarding the wound depth, Wound Nurse B measured the depth of the wound and stated, 1.1 cm (deep). When asked about the visible tunneling, Nurse B measured wound tunneling and stated, 2.5 cm (deep- tunneling) at the 11 o'clock position. The second open wound, contained within the pressure injury area was distal to the left parasacral area. The open wound bed was approximately a quarter in size with yellow tissue covering 50 percent of the bed. After cleaning the wound beds, Nurse B applied a gauze dressing with an ointment over the pressure injury areas. When queried regarding the ointment, Nurse B indicated the wound treatment was medihoney. After completion of wound care, Nurse B proceeded to pull the visibly soiled brief over the new dressing applied to the Resident's coccyx/sacral pressure ulcers. At this time, Nurse D stated, We need a new brief. During care and repositioning following wound care, Resident #18 was observed displaying facial grimacing and non-verbal signs and symptoms of pain. When asked if they were in pain, Resident's #18 indicated they were. Following care, Resident #18 was positioned on their back in bed by staff. Review of Resident #18's wound documentation on 9/25/19 revealed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-7/19/19: Weekly Skin Assessment . Right heel necrosis 85% of wound with yellow slough noted, moderate amount serosanguinous drainage noted. S/P (Status Post) Unstageable debrided in hospital 6 cm (centimeters) X 6 cm X 0.3 cm no odor. Left heel Stage three 4 cm X 4 cm maroon in color pink periwound with small amount of yellow tissue noted, lateral side of left foot ecchymotic maroon in color. Bilateral buttocks/coccyx 4.5 (cm) X 5 cm with 2 wounds underneath left buttock measures 1.5 cm X 1 cm yellow slough in center pink periwound moderate drainage irregular edges . Low air loss mattress. Soft heel lit boots. Roho cushion while in chair turn/reposition q2h (every two hours)/prn (as needed). -8/2/19: Wound Care Nurse Practitioner Progress Note: Left heel is a Stage 3 Pressure Injury . measurements are 3 cm length X 2.7 cm width . small amount of serous drainage . Wound bed has pink epithelialization . Irregular edges . Right heel is a Stage 3 Pressure Injury . measurements are 4.2 cm length X 3.4 cm width X 0.3 depth . moderate amount of sero-sanguineous drainage noted. Wound bed has Necrotic base . Irregular edges . Left Parasacral is a Stage 3 Pressure Injury . measurements are 4.7 cm length X 4.1 cm width X 0.7 cm depth . moderate amount of serous drainage . yellow necrotic tissue . Irregular edges . Plan . Treatment Recommendations: Medihoney Gel Daily and PRN (as needed) to all open areas. Pressure Relief/Offloading: Low Air Loss Mattress . Frequently Reposition; Roho Cushion for wheelchair; Float Heels; Soft Heel Lift Boots . -8/16/19: Wound Care Nurse Practitioner Progress Note: Left heel is a Stage 3 Pressure Injury . measurements are 2.7 cm length X 1.7 cm width X 0.2 depth . small amount of serous drainage . Irregular edges . Right heel is a Stage 3 Pressure Injury . measurements are 5.1 cm length X 5 cm width X 0.3 depth . moderate amount of sero-sanguineous drainage noted. Wound bed has Necrotic base . Irregular edges . Coccyx/L (left) Parasacral is a Stage 3 Pressure Injury . measurements are 8.7 cm length X 5.1 cm width X 1. 1 cm depth . moderate amount of sero-sanguineous drainage . Necrotic base . Irregular edges . Plan . Treatment Recommendations: Medihoney Gel Daily and PRN (as needed) to all open areas. Pressure Relief/Offloading: Low Air Loss Mattress . Frequently Reposition; Roho Cushion for wheelchair; Float Heels; Soft Heel Lift Boots . -8/23/19: Progress Note . Left heel is a Stage 3 Pressure Injury . measurements are 1.6 cm length X 1.1 cm width X 0.01 depth . moderate amount of serous drainage . Wound bed had Necrotic base . periwound skin texture is normal . Irregular edges . Right heel is a Stage 3 Pressure Injury . measurements are 5.3 cm length X 4.2 cm width X 0.01 depth . small amount of sero-sanguineous drainage noted. Wound bed has Necrotic base . Irregular edges . Coccyx/L (left) Parasacral is a Stage 3 Pressure Injury . measurements are 7.7 length X 4 cm width X 0.6 cm depth .large amount of sero-sanguineous drainage . Necrotic midcore, Irregular edges . -9/20/19: Wound Care Nurse Practitioner Progress Note: Left heel is a Stage 3 Pressure Injury . measurements are 0.8 cm length X 0.7 cm width X 0.3 depth . moderate amount of serous drainage . Necrotic Base . periwound skin texture is normal . periwound skin color is normal . Irregular edges Right heel is a Stage 3 Pressure Injury . measurements are 6.2 cm length X 5.3 cm width X 0.01 depth . moderate amount of sero-sanguineous drainage which has a strong odor. Wound bed has Necrotic base . Irregular edges . Coccyx/L (left) Parasacral is a Stage 3 Pressure Injury . measurements are 7.2 cm length X 5.2 cm width X 0.7 cm depth . moderate amount of sero-sanguineous drainage . Wound bed has pink base epithelialization, Minimal Yellow Slough, Two wounds with a bridge granulation . Irregular edges . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/25/19 at 12:28 PM, an interview was conducted with the Director of Nursing (DON). When queried regarding measurements of wounds obtained during wound care observation and last documented wound measurements on 9/20/19, the DON reviewed the medical records and stated, I will have to look into it. When queried regarding the frequency Resident's should be repositioned, the DON replied, Every two hours. When queried regarding observations of Resident #18's heels being positioned directly on the bed and not having heel boots in place, the DON indicated the Resident should have their heel boots on. An interview was conducted with the facility Administrator on 9/25/19 at 3:04 PM. When queried regarding the Turn/Reposition Record observed incomplete in Resident #18's closet. The Administrator indicated the form was not related to turning and repositioning Residents. When asked why the form was titled, Turn/Reposition Record, the Administrator indicated they were not using the forms. The Administrator further revealed no facility would ever use a form like that. No further explanation was provided. 34911 Review of Resident #14's (R#14) Electronic Health Record (EHR) revealed, R#14 was admitted into the facility on [DATE] with diagnoses that included, Stage 2 Pressure Ulcer on Coccyx (tail bone area), Pressure Ulcer Right Heel, Anxiety Disorder, Schizo-affective Disorder, and Conversion Disorder. The most recent Minimum Data Set (MDS) dated [DATE] revealed R#14 was totally dependent on staff for Activities of Daily Living (ADLs) including bed mobility and had a severely impaired cognition. R#14's Treatment Administration Record (TAR) revealed no treatments ordered for wound care, turning and repositioning, or low air loss mattress settings. Interventions on R#14's care plan dated 1/9/19 included, APPROACH: Provide assist with repositioning at regular intervals Flowsheet: CNA (certified nursing assistant) Discipline: Nursing Frequency: Every 2 Hours; 12:00 AM, 02:00 AM, 04:00 AM, 06:00 AM, 08:00 AM, 10:00 AM, 12:00 PM, 02:00 PM, 04:00 PM, 06:00 PM, 08:00 PM, 10:00 PM. The care plan did not specify the method of repositioning. On 9/23/19 at 9:38 AM, R#14 was observed lying in bed and made eye contact but did not speak or move. R#14's bed was in semi-Fowler's position (on their back with the head and trunk raised 30 degrees), a low air loss mattress (for the prevention and/or treatment of pressure ulcers) was set at maximum pressure. On 9/24/19 at 5:23 AM, and 7:52 AM, R#14 was observed in the semi-Fowler's position. At 9:41 AM, Nurse D was asked about the low air loss mattress setting and stated, Nurse B sets them. This setting can be lowered. Nurse D then reduced the pressure setting after releasing the settings lock then re-locked it. R#14 remained in semi-Fowler's position, but now a pillow was observed under the resident's right arm. On 9/24/19 at 12:30 PM, R#14 was being examined by a Physician followed by care by nursing staff. At 1:00 PM, R#14 was observed flat in bed. On 9/25/19 at 9:33 AM, CNA I was asked about caring for dependent residents and stated, I check on them every two hours and change them if needed, and I turn them too. CNA I was asked how the positioning of a resident is maintained and stated, It depends on what kind of bed it is. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/25/19 at 11:30 AM, the Director of Nursing (DON) was asked about the policy and procedure regarding turning and repositioning dependent residents and stated, They are to be turned every two hours. The nurses and nurse managers should be checking to make sure the CNAs are doing their work. There will be more in-servicing. Review of facility policy entitled, Preventative Skin Program (Revised: 2/23/19) revealed, It is the policy of this facility to take steps to reduce the incident of pressure injury development . Licensed Nurse will complete skin assessments, no less than weekly . to identify any new wound concerns or changes with existing wounds . Skin care interventions will be implemented by the licensed Nurse upon identification of any new or worsening wound concern . Documentation of weekly skin observations shall be rendered in the clinical record . Routine off-loading shall be an intrinsic part of the preventative skin care program . The wound care team shall make weekly rounds on residents with identified wounds and routinely query staff to identify skin issues .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 37668 This Citation Pertains to Intake Number MI00105749. Based on interview and record review, the facility failed to identify risk, implement fall prevention interventions, and evaluate appropriateness and effectiveness of interventions for one (#44) sampled Resident with a known history of falls, resulted in an Immediate Jeopardy (IJ) when the Resident fell , suffered a severe injury, and subsequently died . The Immediate Jeopardy (IJ) started on [DATE] and was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] and was asked for a plan to remove the immediacy. The IJ was removed on [DATE], based on the facility's implementation of the removal plan as verified onsite on [DATE]. Although the immediacy was removed the facility's deficient practice was not corrected and remained isolated with actual harm that is not immediate jeopardy. Findings include: Record review revealed Resident #44 was admitted into the facility on [DATE] with diagnoses of repeated falls and stroke. Review of the Admission Nursing Comprehensive Evaluation dated [DATE] revealed the Resident was alert to person and time only and required the assistance of one person and a walker for ambulation and transfers. Review of the resident's care plan entitled, Falls: Resident with hx (history) of falls (Start Date: [DATE]). The care plan included one intervention, Encourage to use call light: Once A Day; 9:00 AM (Approach Start Date: [DATE]). Review of facility provided Unusual Occurrence Report for Resident #44 on [DATE] revealed, Incident Date: [DATE]; Time: 7:22 AM . Location: Resident Room . Resident observed laying on back on floor in between the dresser and chair in room . Nature of Occurrence: Fall . Indicate location of injury: (back of head circled) . Resident Outcome: Bruise/Hematoma . MD Notified: 7:22 AM . Family/Legal Representative notified: 7:30 AM . Measures immediately implemented to prevent reoccurrence: Call light within reach; Frequent Rounding; Immediately sent to ER for eval . Person preparing report: (Nurse K) . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Witness J on [DATE] at 5:58 PM. When queried regarding Resident #44, Witness J stated, (Resident #44) died on the 30th from a bleed. With further inquiry, Witness J indicated Resident #44 fell in the facility on [DATE], hit their head, and died from an intercranial hemorrhage. Witness J further revealed the Resident had been taking Coumadin (blood thinner medication) and had been admitted to the facility from the hospital for a mild stroke. After being notified of Resident #44's fall and transfer, Witness J indicated they went to the hospital Emergency Department to see Resident #44. Upon arrival to the Emergency Department, Witness J stated, (Resident #44) told me what happened. It was around 6:00 AM. (Resident #44) was in their room in bed. There was a nurse in the room and (Resident #44) told the nurse they had to go to the bathroom. The nurse told (Resident #44) they don't do that (assist Residents to the bathroom) and that they had to put on their call light (for a Nursing Assistant to come assist them). (Resident #44) said they put on their call light, but no one came in, so they went (to the bathroom) by themselves. They fell backwards when they were going back to bed. Witness J then revealed Resident #44 never fully recovered and was placed on Hospice prior to their death. At this time, Witness J shared Resident #44's death certificate. The Certificate of Death was dated [DATE] and revealed Resident #44's cause of death as Complications Following Subdural and Subarachnoid Intracranial Hemorrhage . Approximate Interval Between Onset and Death: 6 Weeks . The Death Certificate further revealed, Manner of Death: Accident . Date of Injury: [DATE] . Describe How Injury Occurred: Fall . Location: Lakeside Manor . Record review of Resident #44's medical record documentation on [DATE] revealed the following progress notes: -[DATE] at 1:11 PM: Nursing . New admit day #2 . pt (patient) appears A/O (Alert and Orientated) x 2 w/ mild confusion at times. Pt presents w/ very pleasant affect & able to make all needs known at this time. Pt observed ambulating w/ walker from home but becomes very unsteady at times. W/C (wheelchair) assigned to pt. Education provided regarding safety awareness & w/c safety. Pt also informed to request assistance when transferring Pt currently on warfarin (Coumadin) therapy; PT/INR (laboratory testing) to be obtained Tues & Fri . call light encouraged. -[DATE] at 3:05 PM: PM&R (Physical Medicine and Rehabilitation) consult to evaluate rehab needs, pain mgmt. and coordination of therapy course . Patient was admitted to (Hospital) on [DATE] s/p (status post) fall and mental status change secondary to encephalopathy. D/t (due to) weakness (Resident) was transferred to subacute rehab . I was asked by nursing staff to see patient for decreased independence and back pain. Patient was sitting up right in wheelchair, and seemed stressed that they are unable to get themselves into bed . Complains of lower back pain and inability to do things themselves . LE (Lower Extremities) generalized weakness . Assessment: Gait dysfunction . Difficulty walking .Debility . -[DATE] at 7:40 AM: Nursing . Resident had a unwitnessed fall. Observed resident laying on his back on the floor in between the dresser and chair in his room. No s/s (signs/symptoms) of distress. Resident has c/o (complaints of) pain 3 out of 10 in head. Bruising noted to the back of head. Resident is currently on Coumadin 2.5 mg (milligrams) one time a day. MD notified and advised to transfer . to hospital. (Family) notified via voicemail. BP (Blood Pressure) ,d+[DATE], P (Pulse) 55 . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #44's Admission Fall Risk (Acuity), dated [DATE] revealed, Observation Details: Mental Status . Intermittent Confusion, Poor Recall, Judgment, Safety Awareness . Balance and Gait . Required Use of Assistive Devices . Ambulation/Elimination Status . Impaired Mobility/Continent (assist with toileting) . Does the Resident have a history of falls in last 3 months? . One or Two Falls . Fall Risk Score- Score of 10 or higher represents a high risk for falls . Total Fall Risk: 15 . Initiate Plan of Care . Additional review revealed an order for Resident #44 dated [DATE] which indicated, Pt/INR (laboratory testing for blood coagulation) every Tuesday and Friday, Once a day . 6:00 PM Review of Resident #44's Laboratory Testing Results in the Medical Record revealed PT/INR laboratory testing was completed once, on [DATE] at 8:49 AM, while the Resident was residing at the facility. Review of Resident #44's hospital referral documentation revealed an Emergency Report History and Physical, dated [DATE], which disclosed, Final Diagnoses . Frequent Falls . Subtherapeutic Coumadin coagulopathy . The patient has been falling frequently. Last fall was several days ago . has not hit head in over a week . A phone interview was conducted with Nurse K on [DATE] at 11:40 AM. When queried regarding Resident #44's fall in the facility on [DATE], Nurse K indicated they were assigned to care for the Resident on the day of the fall and stated, It was towards the end of my shift and I heard someone yelling help. I went in and saw (Resident #44) on the floor. I got someone to help me get (Resident #44) up. When asked about the location of the Resident in the room and what the Resident was doing, Nurse K stated, I wasn't sure where they were going. (Resident #44) was near the dresser and the chair by where the TV is (at end of the bed). When asked about the Resident's condition when they found them on the floor, Nurse K stated, He was pretty confused. With further inquiry regarding Resident #44's baseline mental status, Nurse K stated, (Resident #44) had moments of being out it. With further inquiry, Nurse K stated, There was no bruising but towards the back of (the Residents) head was a little red. When asked what interventions were in place to prevent falls at the time of the fall, Nurse K revealed the Resident was on frequent checks. With further inquiry pertaining to fall prevention interventions, Nurse K indicated they were not aware of any other interventions in place. On [DATE] at 11:52 AM, an interview was conducted with Nursing Assistant L. When queried regarding Resident #44's fall on [DATE], Nursing Assistant L indicated they did not have the Resident and did not remember the incident. Nursing Assistant L then reviewed the assignment sheets and stated, (Nursing Assistant M) had that Resident. A phone interview was attempted to be conducted with Nursing Assistant M on [DATE] at 11:59 AM but was unable to be completed due to the phone number provided by the facility no longer being in service. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on [DATE] at 12:04 PM. When queried regarding interventions to mitigate the risk of falls and injury from falls for Residents who are at risk for falls within the facility, the DON stated, We put people closer to the nurses' station, do frequent checks, fall mats. When queried regarding Resident #44, the DON revealed the Resident had frequent falls prior to admission to the facility. When asked what fall interventions in place for Resident #44 due to their history of falls and Coumadin therapy, the DON indicated frequent rounding was in place. Resident #44's fall care plan was reviewed with the DON at this time. When queried regarding Resident #44's fall care plan only including the intervention to encourage call light use, the DON did not provide an explanation. When asked about the Resident's room in proximately to the Nurses' Station, the DON reviewed the Resident's medical record and indicated the Resident was in room [ROOM NUMBER]. With further inquiry, the DON revealed room [ROOM NUMBER] is at the end of the hall and not near the Nurses' Station. The DON then stated, Yes, we should have had (Resident #44) closer to the Nurses' station, done frequent checks and fall mats. When queried regarding the last time the Resident had urinated prior to the fall, the DON stated, I'm not sure. When queried regarding Resident #44's order for PT/INR monitoring twice a week on Tuesday and Fridays and no results for [DATE], the DON reviewed the Resident's medical record and confirmed no diagnostic results were present in the medical record. The DON indicated the results may not have been scanned into the record from the lab and that they would look into it. No laboratory testing results for [DATE] were received from the facility by the conclusion of the survey. Call light software report data availability was requested from the facility on [DATE] at 8:44 AM but not received by the conclusion of the survey. Record review of facility policy entitled, Falls and Fall Risk, Managing (No Date) revealed, Based on previous evaluations and current data, the staff will identify intervention related to the resident's specific risks and causes to try to prevent the resident falling and try to minimize complications from falling . The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling . The facility's removal plan: Resident identified to be affected by the alleged deficient practice. The identified Resident # 44 has expired after being discharged to the hospital Residents with the potential to be affected by the alleged deficient practice. Residents who have a high risk for falls are at risk. We have initiated new fall assessments on every resident to identify this fall risk. This will be completed by end of day. New care plans have been implemented to provide fall risk interventions and CNA care guides have been updated with this information. Staff huddles are in process to inform nursing staff of fall risk residents. Nursing staff who are not on-site will be contacted via phone to inform of the location of this information and will receive in-service education. Systemic Measures (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PRIOR TO ADMISSION: 1. Starting with the next admission, The Director of Nursing will screen residents preadmission information for evidence of fall risk to determine if resident can be safely admitted based on current staffing and availability of fall prevention interventions. 2. New referral will be reviewed to identify previous history of falls and falls with major injury. 3. Once the decision to admit has been made, nursing leadership will meet with the receiving nursing team to give report on the expected need of the new admission. FOLLOWING ADMISSION: 4. The receiving nurse will conduct an assessment and identify residents at risk for falls. 5. DON/Nurse Manager will Identify if there is appropriate interventions in place. In absence of the DON nurse manager, a designated nurse will complete this task. 6. The identified Nurse will assure baseline care plan is completed with initial fall risk information and interventions. ONGOING MONITORING: 1. Should a resident be identified as a fall risk, nursing staff will notify the physician and set interventions in place as needed for each individual. 2. Review of medications to assure which medications might potentially put resident at risk for falls. 3. Nursing Team will complete quality audit tool at least once per week on residents identified with falls risk. 4. Results of quality audit tools and incident reports reviewed during daily clinical review meetings and discuss during the scheduled risk meetings. Team to complete care plan revisions with focus on fall prevention. 5. Schedule meeting/care conference with individuals identified at heightened falls risk. Include the patient representative in this discussion to decrease falls. 6. Physician/extender will review fall risk month and document in the EMR. QAPI 1. The Director of Nursing/ Manager will round on fall risk residents daily. 2. QAPI committee will review findings at least quarterly to review data on falls and assure benchmarks are being met. This information will be used to drive policy changes, staff education, and training.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure indwelling urinary catheter care per professional standards of practice for one (#18) of three Residents reviewed for urinary catheters, resulting in the potential for infection and decline in overall health status. Findings include: Record review of Resident #18's medical record on 9/23/19 revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis, neuromuscular dysfunction of the bladder, Methicillin Resistant Staphylococcus Aureus (MRSA- drug resistant organism) infection and pressure ulcers. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS further indicated the Resident had an indwelling urinary catheter and had a Urinary Tract Infection (UTI) within the previous 30 days. On 9/24/19 at 9:53 AM, Resident #18 was observed in their room. The Resident was in bed, positioned on their back. A urinary drainage bag was noted on the right side of the Residents bed. A strong, pungent odor was noted permeating from the the urinary drainage bag. Resident #18's urine in the drainage bag was dark in color and a large amount of sediment was noted in the drainage tubing and drainage collection bag. An interview was conducted with Resident #18 at this time. When asked how often staff provide catheter care, Resident #18 indicated the Nursing Assistants at the facility usually clean the tubing once a day. When queried regarding if they had experienced any urinary tract infections, Resident #18 revealed they had. When asked the last time the catheter had been changed, Resident #18 indicted the catheter was last changed when they were in the hospital. An interview was completed with Unit Manager Nurse E on 9/25/19 at 12:42 AM. When queried regarding Resident #18's catheter and documentation of care, Unit Manager E stated, It's on the TAR (Treatment Administration Record). Review of Resident #18's TAR and Medication Administration Record (MAR) revealed the MAR included documentation of Foley cath care q (every) shift (Start Date: 8/28/19). The documentation did not indicate what was checked on the catheter. There was no documentation of the catheter being changed on Resident #18's MAR or TAR. Review of Resident #18's progress note documentation at this time do not reveal documentation of the catheter being changed. An interview was conducted with Unit Manager Nurse E on 9/25/19 at 2:57 PM. When queried regarding Resident #18's catheter and documentation of the catheter being changed, Nurse E indicated indwelling urinary catheters are not routinely changed unless there is a problem with the catheter per facility policy/procedure. When asked what would constitute a reason to change an indwelling urinary catheter, Nurse E indicated a blockage. When asked about observations of Resident #18's catheter having sediment and strong odor, Nurse E indicated they would look at the catheter. Nurse E then assessed the Resident's catheter and stated, We are going to change the catheter and send a UA (urinalysis). No further explanation was provided. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 9/25/19 at 3:05 PM. When queried regarding observations of Resident #18's catheter, documentation of care, and Unit Manager Nurse E statements including they were changing the catheter and obtaining a UA, the DON did not provide further explanation. Review of facility policy entitled, Catheter Care, Urinary (Dated 8/1/16) revealed, The purpose of this procedure is to prevent catheter-associated urinary tract infections . Changing Catheters . Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags backed on clinical indications such as infection, obstruction, or when the closed system is compromised .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34911 Based on observation, record review, and record review the facility failed to label tube feeding containers and other tube feeding equipment with a resident's name, the tube feeding formula, or the date of administration affecting one resident (R#14) of one resident reviewed for tube feedings resulting in the likelihood of residents receiving other resident's tube feeding formula or outdated tube feeding formulas. Findings include: Review of Resident #14 (R#14's) Electronic Health Record (EHR) revealed, R#14 was admitted into the facility on [DATE] with diagnoses that included, Stage 2 Pressure Ulcer on Coccyx (tail bone area), Pressure Ulcer Right Heel, Anxiety Disorder, Schizo-affective Disorder, and Conversion Disorder. The most recent Minimum Data Set (MDS) dated [DATE] revealed R#14 was totally dependent on staff for Activities of Daily Living (ADLs) including eating and had a severely impaired cognition. R#14's current Treatment Administration Record (TAR) and current care plan did not indicate the tube feeding formula, rate of administration, or the time frame of the tube feeding administration. On 9/23/19 at 10:05 AM, R#14 was observed lying in bed in the semi-Fowler's position, unresponsive to the knocking on the door or greetings. A tube feeding was observed to be in progress via a tube feeding pump at the rate of 75 milliliters (ml) an hour. The amount delivered by the tube feeding pump indicated that 991 ml had been delivered. The tube feeding formula bag, water flush bag, and the tube irrigation piston syringe and solutions were not labeled with the resident's name, the type of solutions, or the type of tube feeding formula being administered. On 9/23/19 at 10:55 AM, Nurse G was asked about the facility's policy and procedure and stated, It should be labeled. [R#14] gets Glucerna (a formula of tube feeding for those with Diabetes). Nurse G was asked when R#14's tube feedings are started and stated, I didn't start it, it's started on the midnight shift. On 9/24/19 at 6:01 AM, Nurse P was asked about the facility's policy and procedure regarding tube feedings and and stated, It should have been labeled. Nurse P was asked when R#14's tube feedings are started and stated, On the day shift. On 9/25/19 at 10:58 AM, the Director of Nursing (DON) was asked about the policy and procedure regarding tube feedings and stated, They (the nurses) should be labeling them with the name, date, and rate. There will be in-servicing. Review of the facility's policy and procedure regarding tube feedings titled, Enteral Tube Feedings via Syringe dated as Revised 8/01/2016 revealed the labeling of tube feeding bags/containers was not addressed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure respiratory care equipment was available for one (Resident # 37) of three Residents reviewed for respiratory care, resulting in lack of in room equipment, Resident verbalization of dissatisfaction, and the potential for delayed medication administration. Findings include: Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD- respiratory), Atrial Fibrillation (irregular heart rate), and kidney failure with dialysis dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and was independent to total assistance to perform Activities of Daily Living (ADLs). On 9/23/19 at 1:42 PM, an interview was conducted with Resident #37 and Confidential Witness S. When queried regarding their stay in the facility, Resident #37 stated, I'm supposed to have the breathing treatments four times a day and I haven't gotten them. With further inquiry, Confidential Witness S and Resident #37 both revealed the Resident did not have a nebulizer machine in their room to receive the treatments. When asked, Confidential Witness S indicated the Resident was using the nebulizer machine four times a day when they were home due to their COPD. When queried if they ever felt short of breath, Resident #37 indicated they do at times. When asked if they had asked staff about the nebulizer and not receiving treatments, Resident #37 replied, They don't listen. They (staff) won't talk to you and then most of them don't talk English (when come into room). Observation of Resident #37's room at this time revealed a nebulizer machine was not present within the room. Review of Resident #37's provider orders and Medication Administration Record (MAR) revealed an active order dated 8/29/19. The order revealed, or, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligram)/3 mL (milliliter) inhale orally every 6 hours as needed for SOB (Shortness of Breath) . The MARs for August and September 2019 revealed Resident #37 had not received any breathing treatments while at the facility. Review of progress note documentation in the medical record revealed the following note dated 8/28/19, Internal Medicine Progress Note . Following up on this patient for complaint of cough . States has just had rehab this morning and is somewhat short of breath however denies respiratory distress . An interview was conducted with the Director of Nursing (DON) on 9/25/19 at 9:50 AM. When queried regarding Resident #37's order for as needed nebulizer medication administration, not having a nebulizer in their room, and how the Resident would be able to receive the treatment without a nebulizer machine, the DON indicated the Resident should have a nebulizer machine in their room. A tour of Resident #37's room was completed with the DON at this time. The DON confirmed the Resident did not have a nebulizer machine and indicated they would make sure they got a nebulizer machine. A policy/procedure pertaining to respiratory equipment was requested on 9/24/19 at 11:58 AM from the DON but not received by the conclusion of the survey. Review of facility provided policy entitled, Oxygen (Revised 8/16/19) did not include information pertaining to availability of respiratory equipment including nebulizers. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided policy entitled, Documentation of Medication Administration (Dated 6/1/16) did not address availability of nebulizers.

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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. 40384 This citation pertains to Intake: 106242 Based on interview and record review, the facility failed to provide sufficient nursing staff to meet six of eight residents' needs in the confidential group meeting, and four (R23, R36, R41, R193) of 12 sampled residents resulting in complaints of prolonged response to activated call lights, frustration, and unmet care needs. Findings include: On 9/23/19 at 9:05 AM, R36 was asked about their stay in the facility. R36 stated, I was here a year ago and raved to everyone about how nice this place is. I would not do that now. There are nice aides and nurses that work here, but I've waited 2 hours for someone to answer my call light. On 9/24/19 at 8:08 AM, an telephone interview was conducted with Confidential Family Member N who stated, Staff come in, turn off the call lights, and don't come back for hours. One day, [R193] put the call light on. It took them 45 minutes to respond, and then it took them over an hour to clean [R193] up because the peg tube feeding caused frequent bowel movements. On 9/24/19 at 10:04 AM, a confidential group meeting was held with eight residents. Six of the eight resident expressed complaints about prolonged call lights. One resident stated, Call lights aren't answered during the day and night. I'll look down the hall, and the aides will be standing at the nurse's station talking. Another resident stated, The aides will come in, turn off your call light, tell you they'll be back, and never come back. A third resident stated, I've waited hours for someone to come in an change my brief. Another resident stated, We'll get reprimanded if they turn off the call light and we turn it back on to get what we need taken care of. I've had to put my call light on four different times in order for someone to finally respond. The group was asked what the average call light wait time is. Six residents agreed that the wait time is between 30 minutes to 4 hours. 34911 On 9/23/19 at 9:20 AM, R#23 was interviewed regarding their satisfaction with staff answering the call light when help was needed and stated, I have to wait around an hour for anyone to come in, that's a long time when you have to go. R#23 was asked if they had accidents due to long waits for staff to respond to the call light and stated, Yes. On 9/23/19 at 9:53 AM, R#41 was interviewed regarding their satisfaction with staff answering the call light when help was needed and stated, I wait at least 1/2 an hour most of the time.R#41 was asked if they have had accidents due to waiting for staff to respond to the call light and stated, Yes. On 9/25/19 at 2:50 PM, an interview was conducted with the Director of Nursing (DON) in regards to staff complaints regarding call light response time. The DON stated, I know it's an issue. The facility's Nurse Call policy outlines the following, Resident calls must be addressed immediately. Any staff person can address a resident's call. Call lights must be answered quickly.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview, and record review, the facility failed to ensure the medication regimen was free from medications used without adequate indications for use and without documented symptoms for one resident (R42) of six residents reviewed for unnecessary medications, resulting in the risk of serious side effects and adverse reactions from potentially unnecessary psychotropic medications. Findings include: On 9/23/19 at 9:44 AM, 10:54 AM and 11:57 AM, R42 was observed asleep in bed. On 9/23/19 at 2:00 PM, R42 was observed sitting up in their wheelchair asleep. R42 was approached and was asked about concerns that they may have in the facility. R42's family member walked into the room and was also asked about concerns they may have as well. They indicated, They finally got [R42] up. [R42] is always in bed. R42 was observed to have fallen asleep in their wheelchair. On 9/23/19 at 4:00 PM, R42 was observed again asleep in their wheelchair. A review of R42's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included, Diabetes, Dementia with Behavioral Disturbance, and Hypotension. A review of the resident's Minimum Data Set (MDS) assessment revealed that the resident's Brief Interview for Mental Status score was a 15/15 indicating an intact cognition. Further review of the resident's medical record revealed the following: Mirtazapine (antidepressant) Tablet 15 MG (milligrams). Give 1 tablet by mouth at bedtime related to Major Depressive Disorder, Recurrent, unspecified. This medication was ordered on 9/15/19. Wellbutrin SR (antidepressant) Tablet Extended Release 12 Hour 150 MG. Give 1 tablet by mouth one time a day for Depression. This medication was ordered on 8/29/19 On 09/24/19 at 8:03 AM and 3:34 PM, R42 was observed in bed asleep. On 9/25/19 at 8:05 AM, R42 was observed asleep in bed. On 09/25/19 at 10:44 AM, R42 was observed asleep in their wheelchair. On 9/25/19 at 2:00 PM, R42 was observed asleep in bed. Further review of R42's medical record revealed that R42's care plan did not address the resident's use of psychotropic medications, and there were no progress notes indicating the use of two anti-depressants, nor was there any documentation of the resident's symptoms of depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R42's medical record revealed that they were seen by Behavioral Care Solutions for Adults and Seniors on 8/21/19. The note reveals the following, Res (resident) denies insomnia. States that [R42] does feel sleepy during the day Assessment & Plan-Major Depressive Disorder, single episode, Mild. Plan: Continue with Wellbutrin and Remeron (brand name for Mirtapazine). On 9/25/19 at 1:12 PM, Nurse G was asked about R42's daily routine. Nurse G stated, It's difficult to get [R42] out of the room. [R42] doesn't participate in activities Sleeps often. On 9/25/19 at 2:50 PM, an interview was completed with the Director of Nursing (DON). The DON was asked about R42's duplicate therapy for their diagnosis of Depression, and the resident sleeping often. The DON brought in the Nurse E in an effort to provide and explanation. Nurse E was unable to provide an explanation except that, Remeron is sometimes used as an appetite stimulant. A review fo the facility's Psychotropic Medication Management policy outlined the following, It is the policy of this facility to assess residents for appropriate interventions to treat mental illness and to effectively manage psychiatric medications and monitor side effects of these medications. Procedures. 2. Individualized plans of care implemented to include behavior management techniques and include non-pharmacological interventions for behaviors.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34911 Based on observation, interview, and record review the facility failed to ensure medications were swallowed during medication administration affecting one (R#40) of one resident reviewed for unattended medications, resulting in the likelihood of a missed dose, medication hoarding, and/or other residents receiving the medication. Findings include: Record review revealed R#40 was admitted into the facility on [DATE] with diagnoses that included, Vascular Dementia, Hemiplegia/paresis (weakness or paralysis of one side of the body), Essential Hypertension, and Gastroesophageal Reflux Disease (GERD or acid reflux). The most recent Minimum Data Set (MDS) dated [DATE] revealed R#40 had a Brief Interview for Mental Status (BIMS) score of eight indicating a moderately impaired cognition. There were no Physician's orders, assessments, and/or care plans pertaining to self-administration of medications in the Resident's medical record. On 9/23/19 at 10:12 AM, R#40 was observed lying in bed. A medication cup with one dark green oval medication in it was noted at the Resident's bedside. R#40 was asked about the medication and declined to answer. On 9/23/19 at 10:17 AM, Nurse A was asked to identify the medications R#40 was scheduled to receive that morning and stated, I gave them already. Nurse A had a difficult time logging into the Electronic Health Record (EHR). Nurse A accessed R#40's Medication Administration Record (MAR) and stated I gave these. Nurse A was then asked to provide the containers listed on R#40's MAR and provided three medication containers, non of which resembled the medication that was observed at R#40's bedside. Review of the MAR revealed R#40 was scheduled to receive, Aspirin 81 milligrams (mg), Nifedipine ER (for blood pressure) 30 mg by mouth every day, Plavix (for heart disease) 75 mg by mouth every day, Memantine (for dementia) 10 mg twice a day, and Ergocalciferol (Vitamin D) 50,000 units by mouth every Monday. Nurse A was then asked if R#40 was allowed to keep medications at the bedside and stated No. Nurse A then went to R#40's room, asked the resident about the medication and the resident stated, It's from yesterday. Nurse A removed the medication from the room. Nurse A was asked what the medication was and stated, The Vitamin D. Nurse A was then asked if Vitamin D was administered that morning and stated, Yes. That's the thing with [R#40], if you don't watch, [R#40] doesn't swallow them. On 9/25/19 at 2:45 PM, the Administrator and the Director of Nursing (DON) were asked about the policy and procedure on administering medications and the Administrator stated, They are expected to stay with the resident until the medications are swallowed. Review of the facility's policy and procedure regarding medication administration titled, Documentation of Medication Administration dated as, Revised 06/01/2016 did not address leaving medications at the bedside and/or self administration or medications.

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Lakeside Manor Nursing and Rehabilitation Center	13990 Lakeside Circle Sterling Heights, MI 48313

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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 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. 22960 Based on observation, interview, and record review, the facility failed to properly date and store food items, and failed to maintain the dishmachine room in a sanitary manner, resulting in the increased potential for foodborne illness and cross contamination. This deficient practice had the potential to affect 32 residents that consume food from the kitchen. Findings include: On 9/23/19 at 8:45 AM during an initial tour of the kitchen with Certified Dietary Manager (CDM) H, the following items were observed: 1. In the walk-in cooler, there was a container of chili with a preparation date of 9/14/19 and a use by date of 10/14/19. CDM H confirmed the use by date should not have gone past 7 days. In addition, there was a container of egg salad, opened on 9/15/19 with a use by date of 10/15/19. The manufacturer's use by date was noted to be 9/27/19. When queried, CDM H stated, We shouldn't be going past that date. According to the 2013 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. 2. In the walk-in freezer, there was a box of frozen, folded cheese omelets which were open to the air, and there were ice crystals on the uncovered omelets. CDM H confirmed that the frozen food items should be stored covered. 3. There was a container of chicken breasts in the sink, submerged under running water. The temperature of the water was measured to be 72 degrees Fahrenheit, and the temperature of the chicken was measured to be 70 degrees Fahrenheit. When queried, CDM H stated, It's only been out of the freezer for about an hour. According to the 2013 FDA Food Code section 3-501.13 Thawing, Except as specified in (D) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be thawed: 1. (A) Under refrigeration that maintains the FOOD temperature at 5 C (41 F) or less; or 2. (B) Completely submerged under running water: 1. (1) At a water temperature of 21 C (70 F) or below,. 4. The top surface of the dishmachine was observed with a buildup of crumbs and debris, and the drainboard on the clean side of the dishmachine was observed with food debris on the surface. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2013 FDA Food Code section 4-501.14 Warewashing Equipment, Cleaning Frequency, A warewashing machine; the compartments of sinks, basins, or other receptacles used for washing and rinsing equipment, utensils, or raw foods, or laundering wiping cloths; and drainboards or other equipment used to substitute for drainboards as specified under S 4-301.13 shall be cleaned: .(B) Throughout the day at a frequency necessary to prevent recontamination of equipment and utensils and to ensure that the equipment performs its intended function;. 5. In the nourishment refrigerator utilized for the storage of resident food items brought in from the outside, there were 2 undated containers of meat, an undated breakfast sandwich, and an undated piece of meat wrapped inside a napkin. When queried about who was responsible for ensuring the resident food items were dated, CDM H stated, Nursing should be dating them. Review of the facility's policy Foods brought by Family/Visitors dated 6/1/16 noted: 6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34911 This citation has two Deficient Practice Statements (DPS). DPS#1. Based on observation, interview, and record review the facility failed to store respiratory equipment in a sanitary manner affecting four (R#14, R#23, 93, and R#244) of four residents reviewed for respiratory care and infections with the likelihood of the preventable spread of infections. Findings include: On 09/23/19 8:53 AM, R#244 was observed lying in bed with oxygen in use by nasal cannula. A nebulizer mask (for administering inhaled medications) was lying unprotected on top of the bedside stand. At 9:00 AM on 9/23/19, Nurse G was asked about the facility's policy and procedure regarding the storage of respiratory equipment and stated, That is not stored correctly. It should be in a bag. Record review of R#244's Electronic Health Record (EHR) revealed R#244 was admitted into the facility on [DATE] with diagnoses that included, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Chronic Pulmonary Embolism and Thrombosis (blood clots). The most recent Minimum Data Set (MDS) dated [DATE] revealed R#244 had a Brief Interview for Mental Status BIMS of 13 indicating an intact cognition. Further review revealed R#244 required extensive assistance with Activities of Daily Living. On 09/24/2019 at 5:23 AM, R#14 was observed lying in bed awake but did not respond verbally to greetings. It was observed that R#14 had a suction machine (for removing excess secretions from the resident's mouth and throat) on the bedside stand. The suction catheter was lying unprotected on top of the bedside stand. On 9/24/19 at 6:00 AM, Nurse P was asked about the facility's policy and procedure regarding the storage of respiratory equipment and stated, That's not how it should be stored. We suction [R#14] PRN (as needed). I did not have to suction [R#14] last night. At 8:55 AM on 9/24/19, R#14's suction catheter remained lying unprotected on top of the bedside stand. Record review or R#14's EHR revealed R#14 was admitted into the facility on [DATE] with diagnoses that included, Seizure Disorder, Schizoaffective Disorder, and Conversion Disorder. The most recent MDS dated [DATE] revealed R#14 had a severely impaired cognition and was totally dependent on staff for ADLs. On 9/25/19 at 8:54 AM, R#23 was observed sitting up in bed eating breakfast. A nebulizer was observed on the bedside stand and the nebulizer mask was lying unprotected on top of the bedside stand. R#23 was asked if a treatment was given recently and stated, Yes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:00 AM on 9/25/19, Nurse O was asked about the facility policy and procedure regarding the storage of respiratory equipment and stated, I didn't give [R#23] a treatment, but it should be in a bag. Record review of R#23's EHR revealed R#23 was admitted into the facility on [DATE] with diagnoses that included, Chronic Respiratory Failure, COPD, and Anxiety Disorder. The most recent MDS dated [DATE] revealed R#23 had a BIMS score of seven indicating a moderately impaired cognition and needed extensive assistance with ADLs. On 09/25/2019 at 11:30 AM, the Director of Nursing was asked about the facility's policy and procedure regarding the storage of respiratory equipment and stated, The policy and procedure is to keep the equipment clean and store it in a clean bag. Not on top of the bedside stand. 37668 Deficient Practice Statement Number Two: Based on observation, interview and record review, the facility failed to ensure Personal Protection Equipment (PPE) was consistently available and maintained in a non-contaminated area per professional standards of practice for one (#93) of one Residents reviewed for transmission-based isolation precautions resulting in PPE being unavailable for a Resident diagnosed with Clostridium difficile (C-diff: spore forming, contagious bacteria which causes diarrhea and is able to live on inanimate objects for up to six months) and the likelihood for cross-contamination and spread of microorganisms. Findings include: On 9/23/19 at 10:00 AM, during the initial tour of the facility, a sign indicating visitors must see nursing staff prior to entering room was observed on Resident #93's door. The room door was closed. There was no PPE or isolation equipment present near or on the door. On 9/23/19 at 11:20 AM, a transmission-based isolation cart was observed in the hall directly outside of Resident #93's room door. An interview was conducted with Unit Manager E at this time. When queried regarding the sign on Resident #93's door, Unit Manager E stated, Contact for C-Diff. When queried why the isolation cart was not in the hall previously, Unit Manager E replied, I don't know it should have been. The only thing I can think of the that they (staff) took it to restock it. An interview was conducted with Nurse A on 9/23/19 at 11:24 AM. When queried regarding observation of the isolation cart not being in hall outside Resident #93's room, Nurse A stated, I put it in the room. When asked why they placed the cart in the room, Nurse A replied, I put it in the room so they would have to put stuff in it. It was missing items. When asked what was missing from the cart, Nurse A replied, Gloves. When queried who is supposed to fill the cart with supplies, per facility policy/procedure, Nurse A stated, I guess we are. When asked who removed the cart from inside the room, Nurse A stated, Unit Manager E. When queried regarding facility policy/procedure pertaining to placing isolation carts within contact isolation rooms, Nurse A did not provide a response. An interview was conducted with Resident #93 on 9/24/19 at 4:07 PM. When queried regarding staff use of PPE and contact isolation precautions, Resident #93 stated, Not everyone wears it (PPE) when they come in. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed Resident #93 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, intestinal obstruction with surgical repair, and Clostridium Difficile (C-Diff- Contagious bowel infection). Review of the Clinical Admission Evaluation dated 9/9/19, revealed the Resident was alert and orientated to person, place, and time, required assistance for bed mobility and utilized a wheelchair for ambulation. Review of Resident #93's care plans revealed an active care plan entitled, I have C. Difficile r/t (related to) immune system (Initiated and Revised: 9/11/19). The care plan included the interventions: -Contact Isolation: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry (Initiated and Revised: 9/11/19) -Disinfect all equipment before it leaves the room (Initiated and Revised: 9/11/19) An interview was conducted with the Director of Nursing (DON) on 9/24/19 at 12:16 PM. When queried regarding facility policy/procedure pertaining to isolation equipment cart placement, the DON indicated carts are to be placed outside of the room in a non-contaminated area. When queried regarding observation of the cart not being present outside Resident #93's room and statements from staff, the DON replied, (Nurse A) should have filled it (isolation cart). Facility Infection Prevention and Control Program Standards, Policies and Procedures, and Antibiotic Stewardship program was requested from the Director of Nursing on 9/23/19 at 9:01 AM. Review of facility provided infection control policy entitled, Antibiotic Stewardship; Number IC053 (No Date) did not reveal information pertaining to isolation precautions and/or PPE.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview, and record review, the facility failed to ensure a bathroom call light was functional for two rooms located on the 200 unit, resulting in the potential for unmet care needs and inability for residents to call for assistance. Findings include: On 9/23/19 at 8:50 AM, the bathroom in room call light cord in room [ROOM NUMBER] was observed on the floor approximately four feet from where it would have been connected to the call light. On 9/24/19 at 10:52 AM, the call light cord remained on the floor in bathroom. Housekeeping staff was observed in the bathroom cleaning. On 9/25/19 at 8:05 AM, the call light cord remained on the floor in the bathroom as it had two days prior. On 9/23/19 at 9:02 AM during initial tour of the facility, the call light cord in the bathroom of room [ROOM NUMBER] was observed on the bathroom floor. On 09/24/19 at 8:05 AM, the call light cord remained on the floor in the bathroom. On 9/25/19 at 8:21 AM, the Director of Nursing (DON) was shown the missing cord in room [ROOM NUMBER]. They were asked if the call light cords should be attached, and the DON stated, Yes. A review of the facility's Nurse Call policy outlines the following, All resident's should have access to a nurse call device in there room .Should staff identify that call light cords are missing, inoperable, or otherwise non-functional in resident rooms or bathrooms, the the Charge Nurse, Director of Nursing and Facility Manager must be informed immediately.