STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	506014	A. BUILDING _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIGAN VETERANS HOME OF CHESTERFIELD TOWNSHIP	47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI 48047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 578 SS=D	Michigan Veterans Home of Chesterfield Township was surveyed for an Initial Certification survey on 8/4/21. Census=24 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578	Member #252's code status was reviewed and deemed accurate for the member's express wishes. All members residing in the home have the potential to be affected by the deficient practice. The Advance Directives for all members have been reviewed for accuracy of member wishes and advanced directive orders. The Home's policy regarding Advance Directives has been reviewed and deemed appropriate. All of the Home's social workers, admission staff, nurses and nurse managers have been educated on the Home's Advanced Directive policy with emphasis on supporting a member's right to request, refuse, and/or discontinue treatment with timely Advanced Directive orders. The Home's Social Worker or designee will audit the Advanced Directives of 6 members for 4 weeks and then monthly for 3 months for accurate Advance Directive orders. The Home's Social Worker or designee will audit all new admissions weekly for 4 weeks then monthly until for 3 months until substantial compliance is met. Audit findings will be forwarded to the QAPI committee for further review and recommendations. The Administrator is responsible for sustained compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 08/23/2021

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.

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	506014	A. BUILDING _____ B. WING _____	08/04/2021

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MICHIGAN VETERANS HOME OF CHESTERFIELD TOWNSHIP	47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI 48047

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update the resident record with a change in code status for one sampled resident (R252) of two reviewed for advance directives, resulting in the potential for unwanted emergency medical treatment and not honoring a resident's/resident guardian's wishes. Findings include: On 8/3/21 at 11:48 AM, during record review, R252's resident code status in their electronic medical record (EMR) was noted to read, "Full Code - Guardian Activated." The record also indicated that the resident was admitted into the facility on 6/16/21 with moderately impaired cognition. Further review of R252's medical record revealed a physician's order that read, "Full Code, Guardian Activated, Active, 6/16/2021." However, a review of R252's care plan did not reveal code status information. Additional review of R252's medical record revealed a, "Do Not Resuscitate (DNR) Order," for the resident, that included: "Guardian Consent: I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law."	F 578	Date of Alleged Compliance: *August 19, 2021*	

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F 578	Continued From page 2	F 578		

The document was signed and dated by R252's guardian on 6/24/21 and signed and dated by the physician on 6/29/21.

On 8/4/21 at 2:03 PM, the Director of Nursing (DON) was asked if she could confirm R252's code status. The DON indicated she would have to go get her laptop to check.

On 8/4/21 at 2:11 PM, the DON came back and stated, "[R252 is] a DNR." When asked if that information should be reflected in R252's EMR, the DON responded, "Yes. It's being edited right now."

A review of the facility's policies/procedures titled, "Advance Directives: Advance Directives," and "Advance Directives: Do Not Resuscitate Order," both dated May 20 th, 2021, revealed the following:

"7. Information about whether the member has executed an advance directive shall be displayed prominently in the medical record...
10. The plan of care for each member will be consistent with his or her documented treatment preferences and/or advance directive...
19. Changes or revocations of an advance directive must be submitted in writing to the Administrator...The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the member assessment (MDS) and care plan...
20. The Director of Nursing or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the member's medical record and plan of care...
5. Do Not Resuscitate (DNR) orders will remain in

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F 578	Continued From page 3 effect until the member (or legal surrogate) provides the home with a signed and dated request to end the DNR order..."	F 578		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure opened biologicals were dated when opened and or labeled with a resident name for one of two medication carts and one of two medication	F 761	No single member has been identified to be affected by the deficient practice. All members who receive any medications that require dates upon opening from the Anchor Bay medication cart and/or refrigerator have the potential to be affected by the deficient practice. All medications, including multi-dose vials, for which an open date could not be verified was discarded and replaced with new medications. The containers were labeled with the open date. The Home's procedure for medication labeling and storage was reviewed and revised. All licensed nurses will be re-educated on the Home's procedure for medication labeling and storage with emphasis on dating medications when opened. The DON or designee will randomly audit medication carts and medication refrigerators weekly for 4 weeks then every other week for 6 weeks until substantial compliance is met. Audit findings will be forwarded to the QAPI committee for further review and recommendations. The DON is	

	responsible for sustained compliance. Date of Alleged Compliance: *August 19, 2021*	

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F 761	Continued From page 4 refrigerators, resulting in the potential for decreased efficacy of the medication. Findings include: On 8/4/21 at 7:58 AM, an observation of medications in the Anchor Bay medication cart was completed with Nurse "A". The first resident had an opened vial of Novolog insulin with no date present on the vial; A second resident had an opened Fluticasone (steroid) inhaler with no date opened present on the inhaler; A third resident had an opened vial of Novolog insulin without the name or date opened on the vial; A fourth (newly admitted) resident had an opened vial of Novolog insulin without the name or date opened on the vial; A fifth resident had opened Novolog and Lantus insulin vials not dated when opened; A sixth resident had a Symbicort (bronchodilator) inhaler opened and with no date present on the inhaler. An observation of the Anchor Bay medication room refrigerator at this time revealed a Tuberculin (TB skin test) vial opened and not dated with the date opened. Nurse "A" reported it was a regular nurse practice to date the vials when opened. On 8/4/21 at 2:01 PM, the Director of Nursing (DON) was interviewed about the expectation and practice for labeling and dating of medication and reported that they had pulled the policy and an education of the nurses was in progress. The DON reported the nurse should label and date the actual medication upon opening as the box can get thrown away. A review of the facility policy titled "Pharmacy Services: Dating of Medications" dated 06/01/21	F 761		

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F 761	Continued From page 5 revealed: This policy lists recommendations based on manufacturer's literature and pharmacy industry standards for expiration dates. Please review the manufacturer's recommendations if you feel a medication's storage conditions are not represented in the policy...Guidelines: Follow these general procedures for the dating of medications: 4. Multi-Dose Vials: a. Any deteriorated or outdated vials will be replaced. b. All multi-dose vials with a preservative are good until the expiration date printed on the bottle. c. Multi-dose tuberculin and insulin vials and pens will be dated by nursing when opened and discarded after 28 days. Exceptions: i. Humalog Mix 50/50 pen 10 days ii. Humalog Mix 75/25 pen 10 days. iii. Humulin N pen 14 days. iv. Humulin 70/30 pen 10 days. v. Novolog Mix 70/30 pen 14 days." F 812 Food Procurement,Store/Prepare/Serve-Sanitary SS=E CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 761 F 812	No single member has been identified to be affected by the deficient practice. All members who receive food from the main kitchen of the home have the potential to be affected by the deficient practice. The manufactures instructions for the Home's stovetop grill and hood were reviewed for cleaning instructions and recommendations. The Home's dietary manager and cooks have been educated that daily, when cool, the stovetop grill top grates and radiant are to be removed to clean places where fat, grease or food can accumulate as directed by the manufacturer. The hood is to be wiped/spot cleaned after each use.	

	All food items in the walk-in refrigerator/cooler that were labeled and dated. Dietary Manager and food service staff were educated on the importance of labeling and dating all opened resident food items. Dietary Manager has inspected the dry storage area for dented food-related cans and any findings of dented cans have been removed and allocated to a specific labeled shelf for dented can. Dietary Manager has provided education to all food service staff. The Home's Administrator or designee will audit the following: Home's stovetop grill and hood daily for 5 days then weekly for 4 weeks then monthly for 3 months for cleanliness. Walk-in refrigerator/cool will be audited daily for 5 days then weekly for 4 weeks then monthly for 3 months for label and dates. Dry storage will be audited daily for 5 days then weekly for 4 weeks then monthly for 3 months for separation of dented cans and non-dented cans. Audit findings will be forwarded to the QAPI committee for further review and recommendations. The Administrator is responsible for sustained compliance. Date of Alleged Compliance: *August 19, 2021*	

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F 812	Continued From page 6 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain kitchen equipment in a sanitary manner, and failed to ensure resident food items were labeled and dated, resulting in the increased potential for cross contamination and foodborne illness. This deficient practice had the potential to affect all residents that consumed food from the kitchen. Findings include: On 8/2/21 at 9:37 AM, the facility's kitchen was observed with the Dietary Manager. During the tour of the kitchen the stovetop grill was observed to have cooked food debris on the top and sides of it. The DM was asked about the cleaning of the grill and stated, "I haven't used it today." The DM explained that whoever used it, would be responsible for cleaning it. The hood vent above the stove was observed with oil drips along the side of it. The two-door oven was observed with a buildup of brown oil, and food debris on the inside door and base of the oven. The walk-in refrigerator/freezer was observed to have an open and undated platter of angel food cake on the shelf. The DM stated, "Oh we had that yesterday." The dry storage area was observed to have a dented can stored on the canned food shelving area. The DM explained that the facility sends dented cans back to the company and that they are to not be in the same area as the non-dented cans.	F 812		

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